LAW REFORM COMMISSION

MANITOBA

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WORKING PAPER

ON

"THE HUMAN TISSUE ACT"

This Working Paper does not necessarily represent the final or conclusive views of the Commission. It is based on our preliminary research only and is circulated for criticism and comment. Comments should be forwarded, not later than April 30, 1985, to the Commission's offices, 521 Woodsworth Building, 405 Broadway, Winnipeg, Manitoba, R3C 3L6.

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CHAPTER 1

INTRODUCTION

In April 1984, the Commission received a reference from the Attorney-General to inquire into and report on the need to reform *"The Human Tissue Act"*, C.C.S.M. c. H180, of Manitoba (a copy of this Act appears in Appendix A). This legislation regulates the removal and use of human tissue and organs after death for therapeutic, educational and research purposes. The Commission has undertaken preliminary research concerning this reference. This Working Paper summarizes this research and sets forth our tentative recommendations for reform in this area. It is published so that we might have the benefit of obtaining public response before reporting our final recommendations to the Attorney-General.

Scientific advances have greatly increased the demand for human tissue and organs. It is now possible to transplant a wide variety of body parts. These include vital organs like the heart, liver and kidneys, and post-mortem donors of these must have sustained brain death with intact circulation.[1] Other human tissue such as the cornea, joints, inner ear parts and skin can be

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[1]Those most suitable to be post-mortem donors of vital organs include persons whose deaths are caused by brain tumor, head trauma, brain injury, aneurysma, asphyxia or poisoning. The legal definition of death in Manitoba is set forth in s. 2 of *"The Vital Statistics Act"*, C.C.S.M. c. V60 which states that " .. . the death of a person takes place at the time at which irreversible cessation of all that person's brain function occurs." This definition implements the Commission's recommendation in its *Report on A Statutory Definition of Death (Report No. 16, 1974)*.

removed some time after circulation has ceased.[2] The demand for human tissue arises not only for surgical transplantation. Cadaveric organs and tissue are also greatly needed for medical research and education.

The experience in Manitoba is similar to other jurisdictions in that the present supply of human tissue and organs is inadequate to meet the increasing demand. The statistics are particularly compelling with respect to renal (kidney) transplants and corneal grafting - two areas of surgical transplantation in which this province is very active.[3] The Commission has been told that there are 85 people in Manitoba waiting for a renal transplant and that roughly 35 people are added to this list annually.[4] This compares to those 120 people who are awaiting a corneal graft operation in this province; most are required to wait from one to three years before a cornea

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[2]The cornea, for example, remains suitable for removal for transplant purposes for approximately 6 hours after the donor's heart has stopped beating.

[3]From 1969 to August, 1984, 299 renal transplants were performed in Manitoba, an average of 20 per year. This information was supplied by Dr. John R. Jeffrey, Director, Transplant Program, Health Sciences Centre, Winnipeg, Manitoba, (personal interview, August 1984). Ms. Joan Roberts, Co-ordinator of the Lions Eye Bank of Manitoba, Health Sciences Centre, Winnipeg, Manitoba has informed us that in 1983, 71 corneal grafts were performed in this province (personal interview, August 1984).

[4]The statistics given are as of August, 1984 and were also supplied by Dr. John R. Jeffrey. We have been advised that kidney transplants in this province are becoming increasingly more successful. The success rate has climbed from 62 percent prior to 1981 to 80 percent since 1981 in the Transplant Program of the Health Sciences Centre. The increase in the success rate is attributed to the use of cyclosporin, an immunosuppressive drug which prevents rejection of a transplanted kidney. This high success rate illustrates that kidney transplantation can no longer be regarded as experimental; rather, it is a well-accepted treatment for end-stage renal disease.

becomes available.[5] The demand for human tissue in the field of medical research and education also exceeds supply. We have learned that physicians in Manitoba find it extremely difficult to conduct research, or instruct medical students on specific organs or causes of death, given the shortage of donated cadaveric body parts.[6]

There is no doubt that the donation of human tissue and organs benefits both individuals and the community alike. When surgical transplantation takes place, a human life may be saved or improved.[7] The community benefits as a whole when human tissue is donated for research and educational purposes. These improvements which can be achieved through the supply of human tissue and organs are not, however, being fully realized due to the shortage of available organs, as previously cited.

One of the principal issues explored in this Working Paper is whether appropriate changes can be made to increase the supply of human tissue and organs. In addressing this issue, the Commission examines the legislative provisions governing the donation of human tissue under "*The Human Tissue Act*" and describes in general terms how these provisions work in practice. Legislative reform and practical suggestions for change are tentatively

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[5]This information was supplied by Ms. Joan Roberts, *supra*, n. 3. Ms. Roberts has informed us that the success rate for corneal grafting is estimated at 90 to 95 percent.

[6]Dr. Peter Markesteyn, Chief Medical Examiner for Manitoba, (personal interview, July 1984); Dr. Bowden, Head of Pathology, Health Sciences Centre, Winnipeg, Manitoba, (personal interview, July 1984).

[7]Renal transplantation, for example, improves the lives of most patients whose kidneys have ceased to function. Although many can be treated by intermittent hemodialysis, this is expensive and time consuming. Prolonged hemodialysis is also very difficult on the patient, both physically and psychologically. *See* Sanders and Dukeminier, "Medical Advance and Legal Lag: Hemodialysis and Kidney Transplants" (1968), 15 U.C.L.A. Law Rev. 267.

recommended. The Commission recognizes that responsible law reform in this area demands not only an appreciation of the urgent need for human tissue and organs. The values of human dignity and personal autonomy must also be appreciated and upheld. Important too are public opinion and community attitudes toward organ donation.

The structure of this Working Paper is as follows. Chapter 2 contains an overview of the present system of organ procurement in Manitoba and an examination of its deficiencies. A discussion of various options for reform, as well as our tentative recommendations for reform, follow in Chapter 3. The fourth Chapter contains a summary of these recommendations. In Chapter 5, we list several outstanding questions which are raised in this paper, and which we wish to consider in our Final Report to the Attorney-General.

CHAPTER 2

HUMAN TISSUE PROCUREMENT IN MANITOBA

I. "THE HUMAN TISSUE ACT"

A. The Law Preceding "The Human Tissue Act"

The common law concerning the donation of cadavers and specific organs was both obscure and unsatisfactory. The person who was charged with the legal obligation to bury the body of the deceased (be it the executor,[1] surviving spouse,[2] or next of kin),[3] was not legally bound to carry out any previously expressed wishes of the deceased regarding the disposal of his remains.[4] As well, it was uncertain whether those persons themselves had the authority to donate the cadaver or to authorize the removal of specific organs from the body for transplant or research purposes.[5]

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[1] *Hunter v. Hunter*, [1930] 4 D.L.R. 255 (Ont. H.C.).

[2] *Edmonds v. Armstrong Funeral Home Ltd.*, [1931] 1 D.L.R. 676 (Alta. S.C., T.D.).

[3] *Miner v. Canadian Pacific Railroad* (1910), 15 W.L.R. 161 (Alta. S.C., T.D.).

[4] *See Williams* v. *Williams* (1882), 20 Ch. D. 659. *See also* W.F. Bowker, "Experimentation on Humans and Gifts of Tissue: Articles 20-23 of the Civil Code" (1973), 19 McGill L.J. 161 at 186.

[5] *See* P.D.G. Skegg, "Authorization of the Removal of Cadaveric Transplant Material at Common Law" (1978), 18 Med. Sci. Law 90 at 91. Here the author suggests that prior to any statutory provision for authorization, the person charged with the duty to dispose of the corpse *may* have been able to authorize removal of transplant material. However, it is recognized that such a conclusion is not free from doubt. *See also* The Law Reform Commission (Australia), *Human Tissue Transplants* (Report No. 7, 1977) where it is concluded, at page 26, that there exists no apparent authority at common law which would enable a person lawfully in possession of a body, or anyone else, to authorize removal of tissue from the body for transplant or therapeutic purposes.

"The Anatomy Act" was the first statute passed in Manitoba to clarify these common law rules.[6] The original legislation authorized the university to obtain unclaimed or unwanted cadavers for purposes of anatomical study.[7] Later amendments permitted a person to consent to the use of his body after death for such study.[8] However, even today that consent must also be approved (either before or after the donor's death) by any person entitled to claim the body.[9]

Although the passage of *"The Anatomy Act"* helped to clarify the common law, it was limited in its scope. In particular, it merely authorized the retention of a cadaver for anatomical examination, following which the remains were to be interred. The statute did not provide for the donation of body parts. Statutory authority for the removal and use of human tissue and organs did not exist in Manitoba until *"The Cornea Transplant Act"* was passed in 1961.[10] The increasing success of transplantation of other parts of the body, aside from the cornea, soon revealed that this legislation was too limited. The Legislature responded in 1968 by passing *"The Human Tissue Act"* which provided for the removal and use of human tissue and organs generally.[11] This Act was patterned from the original *Uniform Human Tissue Act* which had been adopted by the Uniform Law Conference of Canada

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[6]*See "The Anatomy Act"*, S.M. 1947, c. 3. The present legal citation for *"The Anatomy Act"* is *"The Anatomy Act"*, C.C.S.M. c. A80.

[7]*"The Anatomy Act"*, S.M. 1947, c. 3, ss. 5(1) and 6(4).

[8]*"An Act to Amend the Anatomy Act"*, S.M. 1959, c. 5, s. 5.

[9]*"The Anatomy Act"*, C.C.S.M. c. A80, s. 6(6).

[10]"The Cornea Transplant Act", S.M. 1961, c. 9. This Act was patterned after the *Uniform Cornea Transplant Act* which was approved by the Uniform Law Conference of Canada in 1959. *See* Conference of Commissioners on Uniformity of Legislation in Canada, *Proceedings of the Forty-first Annual Meeting* (August, 1959) at 22. This Uniform Act was later replaced by the *Uniform Human Tissue Act*, *infra* n. 12.

[11]*"The Human Tissue Act"*, S.M. 1968, c. 31.

three years earlier.[12]

B. A Summary of "The Human Tissue Act"

The donation of body parts for therapeutic, educational or research purposes is now regulated in Manitoba by *"The Human Tissue Act"*. The Act's scope is limited to the removal and use of organs and tissues after the death of the donor; *inter vivos* gifts are not contemplated by the legislation.

Generally, in Manitoba, before organs can be removed from the body of a deceased person, consent must have been obtained from the donor himself prior to death, or consent must be given by a family member where death has occurred, or is imminent, and no consent has been given by the donor. This approach to human tissue procurement is a modified version of the legislative scheme commonly referred to as 'contracting-in' or 'opting-in'.[13]

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[12]Conference of Commissioners on Uniformity of Legislation in Canada, *Proceedings of the Forty-seventh Annual Meeting* (August, 1965) at 31. In 1970 the Uniform Law Conference of Canada amended the Act and again in 1971 further amendments were made, including a change of title to the Uniform Human Tissue Gift Act. *See* Conference of Commissioners on Uniformity of Legislation in Canada, *Proceedings of the Fifty-second Annual Meeting* (August, 1970) at 36 and *Proceedings of the Fifty-third Annual Meeting* (August, 1971) at 76.

[13]There exists, however, one exception to the general contracting-in scheme of the Manitoba legislation. Subsection 6(1) of the Act allows for the removal and retention of the pituitary gland during an autopsy without the prior consent of the deceased or his relatives. The use of a gland removed under these circumstances is limited to the treatment of persons having a growth hormone deficiency. However, subsection 6(2) disallows this exceptional procedure where the person performing the autopsy has reason to believe either that the deceased, if living, would have objected to the removal of the pituitary gland for this purpose or that the spouse or other designated relative objects. The reasons for this special provision respecting the pituitary gland will be examined later in this paper.

Strictly speaking, 'contracting-in' means that body parts will not be available for transplant or other purposes unless the donor has so consented during his lifetime. Manitoba has adhered to the contracting-in principle, but has extended it by also allowing the deceased's family to consent to tissue removal. This extension has increased the number of body parts available; indeed, in most cases in Manitoba, tissue is removed pursuant to the consent not of the donor, but of his family.

Under subsection 2(1) of *"The Human Tissue Act"*:

> A person eighteen years of age or over may
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> (a) in writing at any time; or
>
> (b) orally in the presence of at least two witnesses during his last illness;
>
> direct that any part of his body or a specified part of his body may be used after his death for therapeutic purposes or for purposes of medical education or for purposes of medical research.

"The Human Tissue Act" does not require that a direction given by the deceased under section 2, whether oral or written, take any particular form. In the case of a written direction, an organ donor card issued by any one of the major agencies involved in promoting organ donation or the provision located on the reverse side of a Manitoba driver's licence, signed by the donor, would suffice. A direction might also be included in the donor's will.[14]

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[14]However, as noted by G. Dworkin, *infra* n. 16, at p. 366, " . . . a direction in a will without more would in most cases be useless, since wills are normally looked at sometime after death, and usually this would be too late for the deceased's organs to be of medical use. The need for speedy communication is paramount and where a person does include a therapeutic bequest in his will it is considered advisable for the donor's doctor and his close relatives to be informed, and also for the request to be recorded separately."

Subsection 2(2) of the Act provides that the direction given under s. 2(1) is full authority for use of the deceased's body parts as specified in the direction, unless there is reason to believe that the deceased withdrew the direction prior to his death. The subsection further stipulates that where an inquest may be necessary, the consent of the medical examiner will also be required. It is to be noted that neither consultation with, nor approval by, the donor's surviving relatives is legally required for the removal and use of the donor's body parts where the donor himself has consented thereto.

Where a person during his lifetime has not made a direction that any part of his body may be used after his death for general or specific purposes, subsection 3(1) of *"The Human Tissue Act"* establishes a priorized list of persons who can make such a direction concerning the deceased's body after he dies. This person is usually the next of kin, but it may be the person lawfully in possession of the body or the Inspector of Anatomy appointed under *"The Anatomy Act"* where the deceased has no spouse, adult child,[15] parent or adult sibling.

The Act does not provide a positive definition of "person lawfully in possession of the body."[16] However, section 1 of the Act does expressly exclude medical examiners and funeral directors from the ambit of that phrase. The absence of a similar exclusionary reference to hospitals supports an inference that a hospital may be a person lawfully in possession. This would mean that where an individual dies in a hospital and has no close relatives and has not himself consented to organ removal, the hospital would have the power to remove organs on its own direction.

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[15]A "child" would include an adopted child. *See* s. 96(1) of *"The Child Welfare Act"*, C.C.S.M. c. C80.

[16]For a discussion of this somewhat ambiguous term in the context of the corresponding English legislation, *see* G. Dworkin, "The Law Relating to Organ Transplantation in England" (1970), 33 Mod. Law Rev. 353 at 366-367, 373-374.

The Act also has a provision which enables a relative of the donor to make a direction, while the donor is still alive, for the use of the donor's body parts after his death. Subsection 3(2) provides that

> Where a person other than a person who has made a direction under section 2 is, in the opinion of a duly qualified medical practitioner, incapable of making such a request and his death is considered by the duly qualified medical practitioner to be imminent,
>
> (a) his spouse; or
> (b) if none, any of his children eighteen years of age or over; or
> (c) if none, either of his parents; or
> (d) if none, any one of his brothers or sisters eighteen years of age or over;

may make such a direction.

A direction given by a person pursuant to section 3 is full authority for obtaining possession of the body and for the removal and use of any part or specified part of the body after death for the purposes specified in the direction, except where another member of the same class of persons is known to object to the direction, or where there is reason to believe that the deceased would, if living, have objected. Where there is reason to believe that an inquiry may be required respecting the cause and manner of the donor's death, consent of the medical examiner must also be obtained.[17]

It is provided in subsection 4(1) that if there is no demand for a donated body part for the purpose specified in the direction, the body shall be dealt with as though no direction had been given. This prevents, for example, the use of a kidney for research purposes where the direction is limited to use for therapeutic purposes and no suitable kidney recipient can be found at the time of the donor's death.

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[17] "*The Human Tissue Act*", C.C.S.M. c. H180, s. 3(3).

II. BARRIERS TO DONATION UNDER THE PRESENT SYSTEM

The Manitoba legislation outlines relatively simple procedures for the donation of organs and tissues for use after death. Yet, as noted earlier, there exists a shortage of human tissue available for therapeutic, educational and research purposes. In this section, we explore the possible reasons for the failure of the existing system to produce an adequate supply of much-needed human body parts.

A. Donation Pursuant to the Direction of the Donor

A system of organ procurement which relies on active, voluntary donation requires a citizenry that is both aware of the need for organs and willing to participate in the donation process.

While no accurate measure of public awareness is available, a recent study conducted in Ontario suggests that, in the view of the public, information respecting the need for organs and the donation process is at present lacking or inadequate.[18]

It would appear that the shortage of organs *for transplantation* cannot be attributed to a general unwillingness on behalf of the public to donate their body parts. We have no accurate measure of the public's attitude in Manitoba toward organ donation, but what indications we do have lead us to believe that the attitude is likely to be quite positive.

> Public polls have frequently shown that substantial majorities of the population are willing to donate organs - 70 percent of American adults under a Gallup Poll reported in *The New York Times* in

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[18]Abt Associates of Canada, Project Report on Public Attitudes to Human Organ Donation (April 11, 1984), at 39-44 (S. Corlett, Senior Research Consultant, Toronto).

> January 1968, 82 percent of Australian adults in a Gallup Poll reported in October 1975, and 57 and 69 percent, respectively, in 1978 in Britain in a National Opinion Poll and a Gallup Poll.[19]

A Gallup Poll conducted in 1983 indicated that 60 percent of the population in the Canadian prairie provinces either had signed or would be willing to sign a donor card for the purpose of effecting a post-mortem gift of vital organs for transplantation, while 30 percent were not willing and 10 percent were undecided.[20]

Even on a conservative interpretation of these statistics, it seems safe to conclude that a significant percentage of the public is willing to donate body parts after death for purposes of transplantation. However, it does not appear that a similar positive attitude exists toward organ donation *for educational or research purposes*. A recent study in Ontario reported:

> Respondents were universally opposed to donating organs or the body for medical research or education. They do not perceive research as a way of helping people and are concerned about the treatment of the body when it is used for education or research.[21]

If the results of this study reflect the views of the general populace, public attitude would appear to present a major (or perhaps even *the* major) obstacle to organ procurement for research and educational purposes.

Although public opinion appears to favour organ donation, at least

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[19]Russell Scott, *The Body as Property* (1981) 89.

[20]Ontario Minister's Task Force on Kidney Donation, Preliminary Report of the Donation Process Subcommittee (December, 1984), Appendix 4 (W.J.S. Marshall, M.D. and M.A. Robinette, M.D., Subcommittee Co-Chairmen).

[21]Abt Associates of Canada, *supra* n. 18, at 3.

for therapeutic purposes, few people sign a donor card.[22] In Manitoba, every licensed driver has the opportunity to express his intention to donate his body parts for transplant and other therapeutic services, medical education or scientific research by signing the provision on the reverse side of his driver's licence. For those who do not drive, donor cards are readily available from most organizations involved in the procurement of human tissue. Every potential donor also has the option of writing his own document expressing his wish to make an anatomical gift after death. Clearly the mechanisms for expressing an intention to donate one's body parts are readily accessible to those who seek them. Lack of opportunity, therefore, cannot account for the large discrepancy between the number of persons who indicate a willingness to donate and those who actually sign a donor card; the explanation must lie elsewhere.

Perhaps the most obvious explanation for this puzzling aspect of voluntary donation is that those who appear to be willing to donate their body parts are merely neglecting to take any steps to make their willingness known. Inaction, procrastination or simply not giving the matter much thought are characteristics of human nature which create obstacles to the success of any voluntary programme. With human tissue procurement, there is the added factor that many people avoid facing the prospect of their own death.

There appears [sic] to be great psychological difficulties which

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[22]Again, no statistics for Manitoba are available. However, the 1983 Gallup Poll (*supra* n. 20) indicated that while 60 percent of the population in the prairie provinces would be willing to sign a donor card for transplant purposes, only 23 percent had actually signed one. Similarly, a poll conducted in early 1984 in Ontario suggested that although 63 percent of those surveyed indicated a willingness to donate their own kidneys upon death, 72 percent of those surveyed had not signed the vital organ donor card on an Ontario driver's licence (*supra* n. 20, Appendix 6A).

inhibit the giving of one's own organs. Freud wrote that:

> Our own death is indeed unimaginable, and whenever we make the attempt to imagine it we can perceive that we really survive as spectators. Hence . . . at bottom no one believes in his own death, or to put the same thing in another way, in the unconscious every one of us is convinced of his own immortality.

A person's body parts are so much a part of his conception of himself that it is as difficult to imagine their being dead as to imagine his own death. It is easy to see how the thought of signing an organ donation card can create fear and anxiety.[23]

In part, the answer may also lie in the unreliability of the opinion polls themselves. It has been suggested that "people tend to do a poor job of answering realistically hypothetical questions about remote, improbable and awesome events . . . "[24] It is possible that not all those individuals who express a willingness to donate in an opinion poll would actually sign a written consent if they were asked to so do.

There exists a further problem which widens the gap between the number of people who appear to be willing to consent to a post-mortem donation of their organs for transplant purposes and the number of organs actually received. Many potential donors who *have* executed written directions for the use of their organs after death are likely not to become actual donors because no fully adequate system has been established for identifying, at the time of death, the expressed wishes of the prospective donor. It is generally agreed that although the organ donor cards and the driver's licence forms serve the purpose of providing avenues for an individual to express his intention to donate, they do not serve well as a means of identifying individuals as donors.

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[23]Steven I. Weissman, "Why the Uniform Anatomical Gift Act Has Failed" (1977), Tr. & Est. 264 at 265.

[24]Jesse Dukeminier, Jr., "Supplying Organs for Transplantation" (1970), 68 Mich. L. Rev. 811 at 830.

> Unfortunately there is little concrete evidence in any country that these cards have substantially increased the availability of kidneys and tissues for transplant. It is not uncommon for leading renal surgeons in communities that have distributed many donor cards to say that they have never encountered a dead kidney donor who carried one.[25]

There are a number of explanations for this observation besides the obvious one that few people carry their donor cards with them at all times. Even when a potential donor carries a donor card or has a signed provision on his driver's licence, many things can prevent the donor card or licence from being brought to the attention of the attending physician. The majority of donors are accident victims or those who have otherwise been admitted to the hospital in an emergency situation. In these circumstances the potential donor is often unconscious. A hospital staff member may have neither the time nor the authority to search the possessions of the individual; the personal effects are therefore usually locked away or turned over to the family.[26] Where the potential donor has been in an accident, the wallet or purse, which would normally contain the donor card or driver's licence, is often destroyed or lost at the scene of the accident. If it is an accident in which the police have become involved, the police may keep the victim's personal effects, and the hospital staff would have no access to them. The absence of a practical and effective means of identifying those who have provided for the post-mortem donation of their organs therefore appears to constitute a serious impediment in the process of organ procurement.

Where an individual has not made any arrangements to donate his body parts prior to being admitted to the hospital, it is, of course, possible for the attending physician or any member of the hospital staff to approach the potential donor with a request for consent to the removal of his organs in the event of his death. It will be recalled that this consent can be in written

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[25]Russell Scott, *supra* n. 19, at 85-86.

[26]Ms. Del Johnston, Kidney Transplant Co-ordinator, Health Sciences Centre, Winnipeg, Manitoba, personal interview, August, 1984.

form or given orally in the presence of at least two witnesses during the patient's last illness. However, asking a dying patient for consent to the post-mortem removal of his organs is a delicate matter, and doctors are understandably reluctant to make such a request. Dr. Irvine Page has written:

> It should . . . not be forgotten in this age of scientific medicine that the physician himself has become to the patient an important medicine. Therefore, he does not destroy lightly that most precious of human qualities, hope. When consent is asked of the donor, [it should be] remember[ed] what it means to the patient and his family.
>
> Methods other than prior consent may be less destructive of hope for continuing life.[27]

Another important fact to consider is that organs which are most suitable for transplant purposes come from people who have died of cerebral tumors, cerebral injury, or sudden coronary attacks. These people are usually unconscious when they enter the hospital or they are otherwise not in a condition to give consent. It would be inappropriate, or indeed impossible, to ask someone who is in a state of shock or blunted consciousness to consider organ donation.

Even in those circumstances where an individual has directed that his organs be used after death and those wishes are known to the hospital staff, there exists yet another potential barrier to the actual removal and use of his organs. Although the human tissue legislation clearly provides that the direction of the donor constitutes full authority for the use of his body parts for the purposes specified,[28] our discussions with those active in the procurement of human tissue reveal that vital organs are rarely, if ever, removed pursuant to the consent of the donor alone. In almost all cases, consent from the family is also sought. This, in practice, gives the family the power to veto the express directions of the donor in circumstances where the family objects to the donation of the deceased's organs.

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[27]Dr. Irvine Page, "The Ethics of Heart Transplantation" (1969), 207 J.A.M.A. 109.

[28]"*The Human Tissue Act*", C.C.S.M. c. H180, s. 2(2).

This reluctance on the part of the medical profession to act in the face of opposition by the deceased's relatives is not surprising. Solicitude for the feelings of those just bereaved and a desire to avoid confrontation are understandable. And while the law does appear clear, few hospitals or physicians would wish to risk the possibility of adverse publicity or face the prospect of legal proceedings by removing organs against the wishes of the family of the deceased.

B. Donation Pursuant to the Direction of the Donor's Family

As described earlier in this paper, in circumstances where a person has not made a direction respecting the use of parts of his body after death, "*The Human Tissue Act*" establishes a priorized list of family members who can make such a direction.[29]

In a case where a potential donor's death either is imminent or has just occurred, the task of obtaining consent from the donor's relatives may be viewed as a difficult one. Where the potential donor is still alive, it is difficult for a doctor to approach the family with a request for consent to remove the patient's organs after death, as he would thereby destroy all hope that the family has for the patient's recovery. Where death has occurred, doctors may find requesting consent for removal of the deceased's organs distasteful for two reasons:

> First, they have just lost a patient and cannot easily move on psychologically to think in terms of removing the patient's [organs]. Second, since time is of the essence, the relatives must be approached when they have just heard of the death, which, even if they may have prepared for it, will still leave them unprepared to listen to overtures concerning [organ] donation and may even cause

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[29] "*The Human Tissue Act*", C.C.S.M. c. H180, s. 3(1), 3(2).

them to be resentful of what they may see as tasteless intrusion into their grief.[30]

The understandable reluctance on the part of attending physicians to approach relatives for consent greatly reduces the number of organ donations.

Another problem which may arise relates to the urgency surrounding the removal of a vital organ for transplant purposes. While in most cases it will be possible in the short time available to make contact with the designated family member,[31] situations may arise where it is impossible to locate the appropriate relative in time to obtain consent for the removal of organs for transplant purposes.

Where contact with the family has been made, consent to the removal and use of the donor's organs must be obtained. No statistics are at present available respecting the frequency with which a request made of family members to consent to tissue removal is met with a refusal. The indications which we do have are somewhat conflicting. In a recent study in Ontario, refusal by families to give consent was viewed by the health professionals surveyed as the major barrier to the procurement of kidneys from persons identified as suitable donors, with unavailability of the family being the second most frequently-cited problem.[32]

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[30]Ian Kennedy, "The Donation and Transplantation of Kidneys: Should the Law be Changed?" (1979), 5 J. Med. Eth. 13 at 17.

[31]Letter from Dr. John R. Jeffery, M.D., Director, Transplant Program, Health Sciences Centre to Mr. C.H.C. Edwards, Q.C., Chairman, The Manitoba Law Reform Commission, October 29, 1984.

[32]Ontario Minister's Task Force on Kidney Donation, Preliminary Report of the Donor Identification Subcommittee (December, 1984), at 12 (C. J. Cardella, M.D., Subcommittee Chairman).

However, at a recent conference on organ donation,[33] a reference panel composed of medical experts in the field of organ transplantation indicated that in their experience, less than 10 percent of families refuse to consent to organ donation if asked. As well, a Gallup Poll conducted on behalf of the National Kidney Foundation in the United States revealed that almost three-quarters of those surveyed who were aware of organ transplants said that they would give permission to have the kidney of a loved one donated after that person's death.[34] We therefore find it difficult at this time to estimate the degree to which lack of familial consent constitutes a problem in the organ donation process.

C. Medical Barriers Within the Organ Donation Process

The Minister's Task Force on Kidney Donation, established by the Ontario Ministry of Health to identify existing barriers to kidney donation and make recommendations for improvements, recently released their preliminary reports at a conference on organ donation held in Toronto.[35] While their findings and conclusions relate specifically to the organ donation process in Ontario, we believe that many of their comments also will be of some relevance to the situation which exists in this province.

The Task Force was divided into subcommittees each of which examined a particular aspect of the organ donation process. The major preliminary findings of the Donor Identification Subcommittee,[36] based on responses to survey questionnaires distributed to medical personnel in Ontario, may be summarized as follows:

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[33]Conference on Organ Donation in the Eighties: A Blueprint for Success, Toronto, December 2-4, 1984, sponsored by The Ontario Ministry of Health.

[34]*Supra* n. 20, Appendix 3.

[35]*Supra* n. 33. Although the focus of the Task Force's study was on kidney donation, many of their comments and suggestions are applicable to the donation of other vital organs as well and, to a lesser extent, to the donation of 'non-vital' tissue such as cornea.

[36]*Supra* n. 32.

- A specific organ donation policy did not exist in approximately 55 percent of all hospitals surveyed.

- 54 percent of hospitals surveyed stated that they did not actively promote organ donation.

- In 72 percent of the hospitals surveyed there was no individual or team that was responsible for co-ordinating the donation process in the hospital.

- There existed some misunderstanding amongst health professionals as to the type of patient who is suitable for consideration as a potential donor.

- Physicians and nurses were the most likely health professionals to initiate organ donation. The organ donor card was responsible for initiating the organ donor process in only a small percentage of cases.

The second subcommittee to report was the Donation Process Subcommittee.[37] Their preliminary conclusions may be summarized as follows:

- Between 45 percent and 80 percent of patients who would be suitable vital organ donors are not being identified as potential donors or, if identified, are not being converted into actual donors. A great deal of potential exists, therefore, for significantly increasing the organ donation rate.

- Approximately 50 percent of doctors and nurses feel that bothering a grieving family for consent inhibits the donation process.

- A significant number of hospital administrators see lack of interest on the part of their medical staff or boards as a barrier to involvement in the organ donation process. Forty percent of responding administrators reported no involvement of their institution in the process and many were unaware of how the process worked.

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[37] *Supra* n. 20.

- Lack of information concerning suitability for organ donation and optimal donor maintenance as well as lack of familiarity with the donation process on the part of health professional constitutes another significant problem.

- A further medical barrier is that organ procurement can be extremely time consuming and disruptive, particularly for staff in Intensive Care Units. Approximately 75 percent of doctors and nurses surveyed stated that time demands are a barrier to participating in the organ donation process.

- Lack of adequate remuneration for participating in the donation process and financial burdens to the hospital budget also appear to inhibit involvement in organ donation.

- Questions of legal responsibility are seen as a barrier to the initiation of the donation process.

- Large segments of the medical community are both unfamiliar and uncomfortable with the procedures for certification of brain death. This may significantly inhibit their becoming involved in organ removal.

- Many institutions lack both clear guidelines and the trained personnel necessary to maintain a brain-dead donor in stable condition until arrangements can be made for organ removal.

The observations of the Donor Transportation Subcommittee[38] and the Organ Retrieval and Distribution Subcommittee[39] included the following:

- Maintenance of the potential non-living donor during the critical time between donor identification and organ transplantation requires the commitment and active collaboration of multiple health care professionals, as well as extensive medical facilities.

  Optimal support of the potential organ donor and recovery

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[38]Ontario Minister's Task Force on Kidney Donation, Preliminary Report of the Donor Transportation Subcommittee (December, 1984) (M.C. Bouffard, M.D., Subcommittee Chairman).

[39]Ontario Minister's Task Force on Kidney Donation, Preliminary Report of the Organ Retrieval and Distribution Subcommittee (December, 1984) (P.A. Keown, M.D., Subcommittee Chairman).

of vital organs also require a critical level of expertise, gained by both education and experience. While anxious to promote organ retrieval to the fullest extent, many physicians not regularly engaged in this process recognize that they do not possess the requisite expertise, and require assistance in donor support.

- The maintenance of a potential organ donor involves a considerable expense to the donating hospital. No mechanism for reimbursing these institutions is currently in place.

- When a suitable vital organ donor is identified in a hospital without transplant facilities, transportation may be required either a) to move the donor to a transplant centre or b) to dispatch an organ retrieval team to the hospital where the donor is located for organ removal. In the former case, following the removal of organs, the donor's body must be promptly returned to a funeral home for preparation for burial. In the latter case, the removed organs must be maintained and transported to the recipient centre for transplantation.

  These procedures require co-ordinated and rapid communications and transportation facilities. As well, it should be recognized that significant transportation costs may be involved in the organ retrieval process.

- Co-ordinated policies and procedures are required with respect to organ storage, tissue typing and organ distribution.

The preliminary reports issued by the Task Force suggest that much room for improvement exists within the organ donation process. Significantly, the Task Force did not identify the present legislative scheme of contracting-in as a barrier to organ procurement. Indeed, they were of the view that no change in the legislation was required.[40]

III. THE BALANCING OF VALUES UNDER THE PRESENT LEGISLATION

The development of most legislative schemes involves a weighing and balancing of the values and interests related to the subject matter of the legislation. An examination of Manitoba's legislation reveals an implicit priorization of various competing interests respecting control over the use of a human body after death.

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[40] *Supra* n. 33.

Overriding power in some cases rests with a medical examiner conducting an inquiry into the cause and manner of death pursuant to "*The Fatality Inquiries Act*".[41] Not only is he authorized to order a post-mortem examinination of the body without the deceased's family's consent in circumstances where death may have resulted from violent or unexplained causes;[42] he is also empowered to cancel a gift of human tissue by withholding his consent to tissue removal where an inquiry into the cause of death may be required.[43] The public interest in ascertaining the cause of unusual death, therefore, takes precedence over all else.

Second priority is given to the wishes of the deceased himself, who may during his lifetime authorize a post-mortem gift of his tissue for specified purposes,[44] or whose known objection to such a procedure overrides any consent given by his family.[45] Value is placed on personal autonomy and control over one's own body, not only during life but also beyond the point of death. This may be viewed as exemplary of our society's belief in freedom of choice and human integrity. However, it has also been said that "[t]he very idea of applying the notion of personal autonomy to a corpse is absurd; at most, personal autonomy is only artificially extended beyond death."[46] Most organs and tissues decompose rapidly after death; nature itself belies the notion of control over bodily integrity when life has become extinct.

The law next recognizes the wishes of the family, who may authorize tissue removal in the absence of known consent or objection by the deceased

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[41]"*The Fatality Inquiries Act*", C.C.S.M. c. F52.

[42]"*The Fatality Inquiries Act*", C.C.S.M. c. F52, s. 8(1).

[43]"*The Human Tissue Act*", C.C.S.M. c. H180, ss. 2(2)(b), 3(3)(c).

[44]"*The Human Tissue Act*", C.C.S.M. c. H180, s. 2.

[45]"*The Human Tissue Act*", C.C.S.M. c. H180, s. 3(3)(b).

[46]Russell Scott, *supra* n. 19, at 260.

during his lifetime.[47] Priority is also assigned among the family members, with the wishes of the spouse, adult children, parents and adult siblings being considered authoritative in descending order. Here, respect is shown for the feelings of close family members, who may have religious, ethical or emotional reasons for wishing either to consent or object to organ removal.

Final priority is assigned to the interest of the sick and the dying in the use of tissues and organs for purposes of transplant or the preparation of therapeutic extracts. Society's interest in medical research and education shares this position. This is not to say that little value is placed on the saving and improving of human life. Rather, it simply demonstrates that, under the existing legislation, freedom to choose on the part of the donor or his family, which may or may not be exercised to benefit the sick, will not be sacrificed in order to obtain needed tissue. Altruism is the underlying ethical principle upon which organ procurement is at present based.[48]

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[47]"*The Human Tissue Act*", C.C.S.M. c. H180, s. 3. However, as noted previously in this paper, even in circumstances where the deceased has expressly provided for the donation of his organs, consent is generally sought from the family, and hospitals will not remove organs in the face of their objection. This, in effect, reverses the priority given by the legislation to the wishes of the deceased and the wishes of the deceased's family. *Quaere* if this understandable reluctance to act pursuant to the donor's direction, where there is objection by the family, violates the principle of personal autonomy to the same degree as would *removal* of the deceased's organs contrary to his wishes? In this regard, it is interesting to note that in a recent survey (*supra*, n. 18, at 25-26), all respondents firmly believed that the next of kin should not be able to countermand a signed organ donor card. Donors were outraged to think that anyone, including their relatives, could override their expressed wishes to donate their organs.

[48]However, it has been suggested that to give away something which one cannot use does not constitute an act of generosity. *See* A. Mayrand, *L'inviolabilité de la Personne Humaine* (1975) 164-165.

Few would disagree with the proposition that increasing the supply of organs and tissues for transplants and other purposes is desirable. In the next Chapter, we examine various options for attempting to effect this goal. First, we consider a number of legislative schemes which offer an alternative to our present system of contracting-in. Some of these alternatives involve a reorganization of the priorities given to the various interests involving control over the use of dead bodies.

We then examine various means by which the supply of tissue might be increased under our existing legislative scheme. As indicated earlier, upholding the value which society places on freedom of choice is not necessarily incompatible with meeting the needs of the sick and the dying for organs and tissues. If the number of persons who exercise their choice in favour of donating their body parts can be increased, and more efficient means developed for converting these potential donors into actual donors, our goal might be attainable without major legislative change.

CHAPTER 3

CONSIDERATIONS FOR REFORM

I. ALTERNATIVES TO THE CONTRACTING-IN SCHEME

A. Compulsory Organ Removal

One approach that attracts little support is legislatively to authorize the removal of needed organs and tissues regardless of any objection by the deceased or his family. There is no doubt that such an approach would increase the number of body parts available. However,

> [i]t is very clear that a compulsory organ removal statute would interfere with very intensely personal interests of both the dying patient and the next of kin. Such a statute would make a dramatic break from long standing tradition with respect to the burial of human bodies.[1]

It is also worthy of note that "[n]owhere, so far as can be ascertained, has a government yet legislated to take a dead body in the face of objection by the deceased; an objection always prevails".[2] The Commission is of the view that compulsory removal is unacceptable, and does not consider it a viable alternative for Manitoba.[2A]

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[1]Steven I. Weissman, "Why the Uniform Anatomical Gift Act Has Failed" (1977), Tr. & Est. 264 at 267.

[2]Russell Scott, *The Body as Property* (1981) 95-96.

[2A]An argument might also be made that compulsory organ removal could constitute a breach of s. 2(a) (freedom of religion) and s. 7 (right to life, liberty and security of the person) of the Canadian Charter of Rights and Freedoms, *Constitution Act, 1982*, Part I.

B. Sale of Organs

Another rather unpopular approach that has been considered by some commentators is the sale of cadaveric body parts. This approach has been suggested in various forms. One alternative is to enable an individual to enter into a contract for sale of his organs while alive, with performance of the contract being postponed until death. Payment could be made at the time of contracting, or upon death to named beneficiaries or the deceased's estate. Obviously, estimating the value of body parts during the seller's lifetime would be most difficult because of the uncertainty as to the eventual time, circumstances and place of the seller's death and the condition in which his organs will be at that time.

The other alternative would involve sale by the deceased's family of his body parts after his death. Although this approach poses less of a valuation problem,

> [s]ales of cadaver parts by next of kin appear more objectionable than if by the decedent himself. Permitting sales by the next of kin may well create anxiety in the patient that his next of kin and physician are not doing all they can to save him.[3]

Any approach involving the sale of cadaver parts presents many difficulties. On a practical level, the mechanical and logistical problems posed by a system whereby cadaver organs are bought and sold would be monstrous.[4] Also, the risk of unhealthy body materials being sold in the market would be high.[5] Furthermore, needed organs might be distributed on the basis of ability to pay.

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[3]Steven I. Weissman, *supra* n. 1, at 266.

[4]*See e.g.*, Steven I. Weissman, *supra* n. 1, at 266; Russell Scott, *supra* n. 2, at 182; Richard M. Boyce, "Organ Transplantation Crisis: Should the Deficit be Eliminated Through Inter Vivos Sales?" (1983), 17 Akron Law Rev. 283 at 296.

[5]Russell Scott, *supra* n. 2, at 183.

> Other protests are based on morality, ethics, and social considerations. Many people disapprove of the sale of human body parts on the ground that it is immoral traffic, objectionable in itself and filled with possibilities of abuse . . . [6]

The Commission rejects as impracticable and contrary to public policy the adoption of a system involving the sale of body parts.

It should be noted that *"The Human Tissue Act"* does not at present expressly prohibit the sale of cadaver parts for valuable consideration. This matter will be addressed more fully later in this paper.

C. Presumed Consent

Presumed consent or 'contracting-out' legislation has enjoyed increasing support as an alternative to a 'contracting-in' or voluntary donation system such as that which exists at present in Manitoba. In its narrowest form, the principle of contracting-out would grant medical personnel the authority to remove usable organs from a deceased person *unless* the deceased had during his lifetime objected to such post-mortem removal. The wishes of the relatives would be irrelevant. A modified version of this approach would recognize the wishes of the family, who could object to organ removal in the absence of known consent or objection by the deceased himself. Presumed consent laws could (but not necessarily would) be accompanied by a requirement that the hospital notify the deceased's family prior to the removal of the deceased's organs.

Because we are of the firm view that, at the present time, it would be unacceptable to ignore completely the wishes and beliefs of the deceased's close family in circumstances where the deceased had not made his wishes respecting organ donation known, we shall limit our consideration herein to the 'modified contracting-out' approach.

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[6]Russell Scott, *supra* n. 2, at 183.

Presumed consent is rarely discussed in the context of the removal and use of cadaver organs for purposes other than transplantation or other therapeutic uses. One reason for this is that, as will be discussed below, proponents of presumed consent laws base their argument, in part, on the proposition that most people are in fact willing to donate their body parts for these purposes. As was noted in Chapter 2 of this paper, opinion polls do provide some support for this proposition. There is no indication, however, that most members of the public are also willing to donate their body parts for medical research or education. A distinction may be drawn between donation for therapeutic purposes and donation for research and educational purposes. The former may be seen to represent a more direct means of aiding human life than the latter, and the degree of urgency attending the need for organs for these diverse purposes may be viewed as differing significantly. For these reasons, most proponents of presumed consent legislation have restricted their discussions to transplant and other therapeutic purposes; our consideration of this approach will be similarly limited.

The arguments in favour of the presumed consent approach are several. First, it is contended that most people are willing to donate their body parts for transplants and other therapeutic purposes. Opinion polls are relied upon to support this contention. Legislation which presumes that a person consents to donation would therefore simply give statutory recognition to the fact that the majority of the population is willing to so do.

Secondly, it is argued that contracting-out legislation recognizes the primacy of our ethical commitment to the preservation of human life. Moreover, by allowing an individual to object during his lifetime to the post-mortem removal of parts of his body, the value which we place on freedom of choice and personal autonomy would not be compromised.

Thirdly, it has been suggested that presumed consent would effectively increase the supply of much-needed organs. On the other hand, the present scheme of voluntary donation is seen as incapable of yielding an adequate supply:

> . . . it is unrealistic to expect . . . people to take the steps currently needed for an organ donation when such a procedure causes fearful anxiety.
>
> . . . .
>
> Unless drastic changes occur in the psychology of man . . . , the quantity of useful organs donated under current donation statutes will not meet the demand for transplantation.[7]

Voicing a somewhat related argument, many commentators have drawn an analogy between organ donation and the making of a will, stating that most of the psychological reasons for not making a will are the same as the reasons for not taking the steps required at present for donating one's organs.[8]

> For the descent of monies, the law has recognized that many people avoid facing the prospect of their own death, and so it has established procedures for the useful distribution of money of those who have died intestate. In the case of organs that may grant suffering patients renewed health or even life itself, the law makes no such provisions.[9]

Presumed consent is seen as a way of 'filling the gap' in the many cases where the deceased himself has failed during his lifetime to make his wishes respecting organ donation known, whether for reasons of fearful anxiety about death, or mere neglect and inaction.

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[7]Jesse Dukeminier, Jr., "Supplying Organs for Transplantation" (1970), 68 Mich. L. Rev. 811 at 830.

[8]*Id.*, at 829; *see also* Richard M. Boyce, *supra* n. 4, at 287.

[9]Benjamin Freedman, "'By Good Appliance Recovered': New Reflections on Organ Transplantation and the Definition of Death in Canada" (1980), 1 Health Law Canada 3 at 8.

Fourthly, an adoption of the presumed consent approach is advocated on the basis that it would minimize the impact of organ removal on both the hospital staff and the bereaved family. Medical personnel would no longer be put in the awkward position of asking a dying patient to consider donating his organs for use after death, nor would they have the difficult task of seeking consent from the deceased's relatives in their moment of grief. Also, the family would not have to face the unpleasantness of being approached for consent and the responsibility of decision-making.

In short, presumed consent is offered as an effective system of organ procurement, consistent with our fundamental values and free of many of the problems which attend the present contracting-in system.

The presumed consent approach is not unprecedented; it has been adopted, for example, in many of the countries of Europe.[10] Several of those nations, including Austria, Denmark, Poland, Switzerland and France, authorize physicians to remove organs without imposing a corresponding obligation to approach families to provide them with an effective opportunity to object.[11] In other countries where presumed consent prevails - Finland, Greece, Italy, Norway, Spain and Sweden - physicians approach the families to be certain that they have no objection.[12]

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[10]We regret that we have not yet been able to access copies of the European legislation and other related primary research materials. Accordingly, our discussion herein is based on information obtained from secondary sources.

[11]A. Cantaluppi, A. Scalamogna and C. Ponticelli, "Legal Aspects of Organ Procurement in Different Countries" (1984), 16 Transplantation Proceedings 102.

[12]*Id.* In Sweden, for example, it is required by legislation that reasonable efforts be made to inform relatives prior to organ removal. If there is reason to believe that the deceased would have objected, or if objection is voiced by the relatives, organs will not be removed. (Prof. Carl Groth, Professor of Surgery, Huddinge Hospital, Stockholm, Sweden, personal interview, December, 1984).

It is noteworthy that even in the United States where the legislation is primarily of a contracting-in nature,

> . . . several states . . . have passed laws allowing removal of organs without the prior consent of the original donor or his family provided there is not enough time to notify the family and no known objection was made by the decedent during his life. [For example], California's Diligent Search Act makes organs available for transplantation after a thorough twenty-four hour investigation into the donor's background is completed.[13]

The arguments that have been raised in favour of presumed consent legislation, and the support that it has received both by commentators and legislatures in many parts of the world, without doubt give this option some credibility and appeal. We accordingly have given it serious thought and consideration.

However, we find questionable several of the arguments upon which advocates of presumed consent rely. More importantly, we are not satisfied that a system of presumed consent would in fact increase the supply of available organs.

First, we are not convinced that the opinion polls which indicate that a majority of persons when polled express a willingness to donate their organs provide a basis for adopting a system of presumed consent in this province. As mentioned in the previous Chapter, these polls may not accurately reflect the number of people who would *actually* consent to donation if asked to so do. At the very least, we do not at present have sufficient data upon which to conclude that the majority of persons in Manitoba would donate their organs and tissues if they directed their minds to the issue.[14]

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[13]Richard M. Boyce, *supra* n. 4, at 290-291.

[14]We regret that time and resources have not allowed us to conduct empirical research to determine this question.

To borrow the analogy between organ donation and the making of a will: the laws of intestate succession attempt to reflect the wishes of the average deceased person, and are essentially "the law's answer to the question 'how would the deceased have distributed his property if he had made a will?'"[15] At this time, we have no basis upon which to answer the analagous question, 'how would the average deceased person in Manitoba have disposed of his body parts if he had expressed his wishes related thereto?'. Without some evidence, the adoption of presumed consent would be the adoption of a mere fiction, a fiction that perhaps would be contrary to the facts.

Furthermore, even if it were to be demonstrated that most citizens are willing voluntarily to make a gift of their organs, this would not imply that a majority of persons would favor the introduction of a legislative presumption of consent. We are aware of only two studies in which public attitude to such legislation was tested. The first of these involved a public opinion poll conducted in Alberta in September, 1983 by the Alberta Human Tissue Procurement Task Force. Although only 37 people responded, the Task Force found that

> [c]learly [the consent issue] remains a contentious area and it is probably safe to assume that the majority of Albertans would not be in favour of mandatory donation or even of implied consent to donation in the absence of express refusal.[16]

In the second study, it was similarly concluded that there is opposition to presumed consent legislation and that it is not viewed by the public as an acceptable alternative in Canada.[17]

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[15]Ontario Law Reform Commission, *Report on Family Law, Part IV: Family Property Law* (1974), at 163.

[16]Alberta Human Tissue Procurement Task Force, *Annual Report 1983/84*, at 18.

[17]Ontario Minister's Task Force on Kidney Donation, Preliminary Report of the Donation Process Subcommitttee (December, 1984), at pp. 9, 11 (W.J.S. Marshall, M.D. and M.A. Robinette, M.D., Subcommittee Co-Chairmen).

Secondly, we are of the view that a system of presumed consent would require the development of an accurate and accessible means for persons to record during their lifetime an objection to post-mortem donation. Similarly, the family would have to be given the opportunity to voice an effective objection where the wishes of the deceased were unknown. Without these measures, presumed consent would, for all intents and purposes, constitute a system of compulsory organ removal; the opportunity to object, which embodies the value placed in our society on the freedom to choose, would exist only in theory. This we find unacceptable.

However, if we were to attempt to develop an effective means for allowing the donor or his family to object to donation, we would merely find ourselves confronted with the flipside of the problems which we now encounter under our contracting-in scheme. Rather than trying to ascertain at the time of death whether the deceased had in his lifetime consented to donation, medical personnel would be faced with the task of determining whether he had objected. Rather than approaching the bereaved family for consent to donation, the physician would consult with the relatives to discover if they had an objection.[18] Presumed consent, therefore, would not appear to be the panacea that some of its advocates seem to suggest.

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[18]Prof. Carl Groth, (*supra* n. 12) confirmed that the practice under the Swedish system of presumed consent differed little from that under a contracting-in legislative scheme. He did, however, make an interesting observation. In his experience, some relatives seemed more comfortable with saying that they had no objection (or with simply voicing no opinion when informed that organ removal was being contemplated) than with stating positively that, yes, they did consent. A similar point was made by Russell Scott, *supra* n. 2, at 96.

Thirdly, and most importantly, the available empirical data does not show that the organ donation rate has been significantly increased in those countries which have adopted the presumed consent approach.[19] An examination of the practice that has evolved in France, since its adoption of this system in 1977, may provide some insight into why this is so.

France, it will be recalled, has in force presumed consent legislation which does not require consultation with the deceased's family prior to organ removal. However, in spite of this,

> . . . doctors [in France] are not willing to remove organs from cadavers without the consent of family members. Strong presumed consent exists only on paper in France. In practice French physicians find it psychologically intolerable to remove tissues from a body without obtaining the permission of next of kin.[20]

Also,

> . . . there [are] severe limits both in terms of personnel and hospital space on the number of transplants . . . that can now be performed. . . .
>
> Moreover, the French, like their American counterparts, find it psychologically difficult to approach grieving family members about the prospect of organ procurement even if only to ascertain whether the family objects . . . Busy emergency room personnel are loathe to take the time necessary to fully discuss the subject of transplantation with distraught family members.[21]

However, mention should be made of the fact that, in France, objections are raised by less than 10 percent of the families who are given the opportunity to refuse consent. As well, there have been no reports of public opposition or dissatisfaction with the presumed consent legislation.[22]

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[19]Ontario Minister's Task Force on Kidney Donation, *supra* n. 17, at 6; Arthur L. Caplan, "Organ Procurement: It's Not in The Cards" in *The Hastings Center Report* (October 1984).

[20]Arthur L. Caplan, *id.* at 11.

[21]*Ibid.*

[22]*Id.*, at 12.

We believe that presumed consent may, to some extent, serve a valuable function in influencing the public to adopt a positive attitude toward organ donation. However, we cannot conclude that the introduction of presumed consent legislation would effectively remedy the present shortage of human tissues and organs.

Finally, we are of the view that many constructive measures can be taken to increase the supply of organs made available under our present contracting-in scheme. The existing barriers to organ procurement, discussed in Chapter 2, reflect more a problem in practice and implementation than a deficiency inherent in the legislation itself. We believe that until efforts to increase the effectiveness of our present legislation are exhausted, the adoption of an alternate legislative scheme (the desirability, workability and effectiveness of which are at best uncertain) would not be justified.

These considerations lead us to conclude that a general scheme of presumed consent should not be introduced in Manitoba at this time. Accordingly, we tentatively recommend:

TENTATIVE RECOMMENDATION 1:

That, subject to Recommendation 2, the requirement of consent to remove human tissue after death for therapeutic, educational and research purposes be retained.

D. Exceptions to Required Consent

1. Life-saving emergency

It may be suggested that the strict requirement for prior consent to organ removal should be relaxed in certain emergency situations. In Quebec, for example, where the legislation basically follows the modified

contracting-in approach found throughout the rest of Canada, the requirements for consent have been made considerably less rigid in limited circumstances. Article 22 of the Quebec *Civil Code* provides that

> A physician may remove a part of the remains, if in the absence of instructions by the deceased, he obtains the consent of the consort or nearest relative of the deceased.
>
> *This consent is not necessary when two physicians attest in writing to the impossibility of obtaining it in due time, the urgency of the operation, and the serious hope of saving a human life.*
>
> The death of the donor must be ascertained by two physicians who do not participate in any way in the removal or in the transplantation.[23] (emphasis added)

It is to be noted that the extraordinary authority conferred by paragraph 2 of Article 22 may only be exercised where there are no known contrary directions by the deceased; neither the spouse nor the next of kin can be reached in time for consent to be obtained; and the organ is urgently required for purposes of a life-saving transplant.[24] As one learned author has pointed out:

> The second paragraph [of Article 22] has no counterpart in any of the legislation [of the other Canadian provinces]. It is notable in permitting the use of part of a cadaver where consent cannot be obtained in time, and where the purpose is to save a human life. This provision doubtless contemplates heart transplants, though it applies to any part of the body.
>
> The Committee [on Civil Rights and Duties] referred to this provision as highly exceptional, and they justified it on humanitarian grounds. Solicitude for the family's wishes must give way to save a life. The Commission pointed out the moral duty to go to the assistance of another - and the taking of an organ is a form of "rescue" of the person whose life will be saved by the transplant.

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[23] S.Q. 1971, c. 84.

[24] A. Mayrand, *L'inviolabilité de la Personne Humaine* (1975) 161-162, wherein he concludes that the "urgency" referred to in paragraph 2 relates not to the urgency of organ removal but rather to the urgency attending the transplant required to save the recipient's life.

> Once again there has been a weighing of human need against the rights of the family over the cadaver and article 22 comes down on the side of human need.[25]

Where attempts to make timely contact with the potential donor's family have been unsuccessful, the argument in favour of recognizing the needs of a dying patient over the unknown views of the family is not without merit. We are of the view that the adoption of a provision dispensing with the need for the consent of the deceased's family in these very limited circumstances is worthy of serious consideration.

However, it is our understanding that these emergency powers for organ removal without consent have never been utilized in Quebec.[26] We have been advised that doctors are unwilling to risk confrontation with the families of potential organ donors and, therefore, proceed with organ removal only where consent has been given.

We invite your views on the following questions:

(a) *Is it necessary or desirable to include in our human tissue legislation a provision dispensing with the need for consent to organ removal when two physicians attest in writing to the impossibility of contacting the spouse or other designated relative in due time to obtain consent, the urgency of the proposed transplant operation and the serious hope of saving a human life?*

(b) *In the above-described circumstances, would physicians in Manitoba feel comfortable making such a written attestation or engaging in organ removal or transplantation pursuant thereto?*

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[25] W.F. Bowker, "Experimentation on Humans and Gifts of Tissue: Articles 20-23 of the Civil Code" (1973), 19 McGill L.J. 161 at 190.

[26] Ms. Colette Dionne-Birks, Co-ordinator, Metro Transplantation, Montreal, Quebec, telephone interview, October, 1984.

2. Autopsies

It will be recalled that in Manitoba, and several other provinces, it is lawful to retain the pituitary gland during a post-mortem examination for use for therapeutic purposes, unless there is reason to believe that the deceased, if living, would have objected or that a designated family member objects.[27] The presumed consent approach, therefore, has been adopted in our province in these very limited circumstances.

The pituitary is a pea-sized gland located at the back of the skull. Used for producing a hormone extract that combats dwarfism in children, this tiny gland has immense therapeutic value.

During a normal autopsy, the pituitary gland is removed and examined. It cannot thereafter be put back in its original place because of the damage done to its connecting tissue by removal. Because it is so small, it would more than likely be treated as waste after the examination and discarded,[28] or else placed in a body cavity along with other severed parts.

The great need for the pituitary for therapeutic purposes and the fact that it is routinely removed during an autopsy without leaving external

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[27]*"The Human Tissue Act"*, C.C.S.M. c. H180, s. 6; *The Human Tissue Amendment Act*, S.N. 1981, c. 41, s. 1; *An Act to Amend the Human Tissue Gift Act*, S.P.E.I. 1980, c. 27, s. 1; *An Act to Amend the Fatality Inquiries Act*, S.N.S. 1982, c. 25, s. 3; *Coroners Act*, R.S.O. 1980, c. 93, s. 29; *The Coroners Amendment Act, 1980*, S.S. 1979-80, c. 57, s. 5; *Fatality Inquiries Act*, R.S.A. 1980, c. F-6, s. 27. In several of these jurisdictions, the provision is limited to *official* post-mortem examinations. Alberta, unlike the other provinces, authorizes the use of the pituitary gland retained under these circumstances for medical education and scientific research, in addition to therapeutic purposes. *See also An Act to Amend the Human Tissue Act*, S.N.B. 1984, c. 25 wherein it is required that reasonable steps be taken to ascertain whether the designated family member objects prior to such removal of the pituitary gland for therapeutic purposes.

[28]Russell Scott, *supra*, n. 2, at 93.

trace have led to the adoption of these special statutory provisions respecting the retention of the pituitary gland. It has been said:

> . . . it would surely be absurd if this tiny severed gland, obtained after a gross interference with the physical integrity of a dead body, could not lawfully be used for curing sickness but must instead be destroyed or sewn up in some other part of the body. The new laws are both practical and humane. . . . The laws are activated only after the [person performing the autopsy] has produced tissue in usable form. It would be a human and economic waste to forbid this use and to compel destruction of the tissue.[29]

The pituitary is not the only body part that remains useful for therapeutic purposes even if removed some time after the deceased's heart has stopped beating. Cornea, bones, joints, inner ear parts and skin may be of therapeutic value if removed during a post-mortem examination. It has been suggested that the supply of these body parts could be increased by allowing for their removal and retention on a basis similar to that at present employed for the pituitary gland.

The argument in favour of expanding the 'pituitary gland exception' to include other human tissue lies primarily in the fact that the performance of an autopsy in itself seriously interferes with the physical integrity of a dead body.

> . . . [It is] the gruesome truth that a properly conducted full autopsy will involve the draining away of all blood and body fluids, and the removal of all organs, glands and the brain. Once the cause of death is ascertained, the body will then be restored to a normal appearance, so far as possible, and handed over to relatives for internment. Frequently, severed parts are carefully placed in a body cavity such as the abdominal cavity, and all incisions are stitched up. But organs and glands cannot be put back in their original positions and there is no point in giving further thought to body fluids.[30]

Once the body has been so extensively interfered with, why should tissue which

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[29]Russell Scott, *supra* n. 2, at 93-94.

[30]Russell Scott, *supra* n. 2, at 92-93.

would be useful in aiding the sick not be retained where there is no known objection by the deceased or his family?

Opponents of this position argue that an autopsy may be a necessary evil, but that one should not compound the affront to bodily integrity by dealing further with the remains in the absence of consent once the procedures for determining the cause of death have been completed: two wrongs do not make a right.

The only Canadian province to have adopted presumed consent legislation in relation to tissue other than the pituitary gland is Saskatchewan. A recent amendment to their *Coroners Act*[31] authorizes the extraction of the deceased's corneoscleral button during an official autopsy where it is expected to be suitable for use for an immediate transplant. This may only be done where the person performing the autopsy has no reason to believe that the deceased expressed an objection to the extraction or that the deceased's close family or personal representative objects. It is our understanding that this recent legislative amendment has met with no negative response from the public or the media.

While we believe that there is some merit in the suggestion that the presumed consent approach be extended to cover the retention during an autopsy of useful tissue in addition to the pituitary gland, we are not prepared to recommend such legislative change in Manitoba at this time. In part, we rely on the reasons for which we rejected the adoption of a general scheme of presumed consent. Most importantly, we believe that the supply of human tissue can be significantly increased without the introduction of such legislation. With regard specifically to increasing the amount of tissue donated where a post-mortem examination is performed, a system of 'routine request', such as that adopted by the office of the Chief Medical Examiner in Alberta, presents a promising option.[32]

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[31]*The Coroners Amendment Act, 1984*, S.S. 1983-84, c. 32.

[32]This and other non-legislative options will be examined in the next section of this Working Paper.

Accordingly, we tentatively recommend:

TENTATIVE RECOMMENDATION 2:

That the presumed consent provisions in s. 6 of "The Human Tissue Act" not be extended to permit the removal and retention of organs or tissue other than the pituitary gland.

II. METHODS OF INCREASING ORGAN SUPPLY UNDER THE CONTRACTING-IN SCHEME

As noted in Chapter 2, many of the factors which at present inhibit the procurement of an adequate supply of tissue appear attributable not to the legislative consent requirements, but rather to the lack of essentially three matters:

1. public awareness and participation;
2. an adequate system for identifying potential donors; and
3. awareness, co-ordination and participation within the medical profession.

We will now examine ways in which these barriers to organ donation may be diminished or eliminated.

A. Public Awareness, Attitude and Participation

A system of voluntary organ donation requires a public that is aware of the progress that has been made in the fields of organ transplantation and medical research, and aware of the desperate need for organs and tissues for these purposes. As well, it is important that organ donation be viewed by members of the public as an acceptable and commonplace matter for consideration, not unlike providing for the disposition of one's property after death. Information respecting the procedures involved in the organ donation process is required, so that people are aware of how to record their wishes to donate body parts, and to allay any fears or misconceptions which may exist in relation to organ donation. Also, constant reminder and

encouragement for members of the public to take the requisite steps to donate their body parts for use after death must be given.

> Under any system that relies on consent, continual encouragement to donate is required - through government and private publicity programs, the media, schools and educational institutions, and the support of all acceptable means of indicating the wish to give. . . . One ethicist, after an examination of human tissue shortages, called for "a firm campaign [to be] waged against our shameful waste of human tissue . . . by ministers, chaplains, doctors (especially general practitioners), teachers, public health officials, publicists, and many others whose support of medicine . . . can still overcome the mini-morality of body taboo.[33]

As well, we believe it important that encouragement be given to those wishing to donate organs to express and discuss these wishes with their close family members.

It was noted earlier in this paper that signed organ donor cards and driver's licence donation forms do not provide an effective means of donor identification. We are of the view, however, that they serve an important purpose, and we encourage their continued use and distribution. Donor cards prompt awareness and consideration of organ donation and may serve to stimulate useful discussion. As well, the existence of a signed donor card assists family members in deciding to give their consent to the removal of the deceased's organs and tissues.

A recent study on public attitudes to human organ donation[34] reported that the respondents spontaneously discussed the need for publicity about organ donation. Their comments and suggestions included the following:

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[33]Russell Scott, *supra* n. 2, at 90.

[34]Abt Associates of Canada, Project Report on Public Attitudes to Human Organ Donation (April 11, 1984), (S. Corlett, Senior Research Consultant, Toronto).

- There is a need for constant, ongoing publicity that would make organ donation a routine, natural thing to do.

- The public wants to hear about actual cases and success stories.

- The public is not adequately made aware of the need for organs.

- More attention must be drawn to the driver's licence attachment respecting organ donation.

- More information is desired regarding the criteria for selecting potential donors, the declaration of death and the status of the body following organ removal. Such information could be included in a pamphlet accompanying driver's licence renewals or incorporated into stories on television.

- Fears that organs may be removed prematurely or that doctors will not do all they can to save the life of a potential donor must be allayed.

- Public awareness campaigns should include instructions to sign organ donor cards.

- Ongoing health-related campaigns such as the blood donor campaigns and the drinking and driving campaigns were cited as good model publicity campaigns.

- Advertising by well-known entertainers or sports personalities was favoured.

Those involved in existing transplant and research programmes have attempted to educate the public about organ donation through the distribution of literature and donor cards, and by making public appearances. However, they have not had sufficient resources to develop the type of large-scale publicity campaign that is required. Public funding and initiative with respect to public awareness programmes, as well as funding of private organizations which are involved in public education relating to organ donation, are required.

We are of the view that public awareness and education forms an

integral part of our voluntary organ donation process. We therefore tentatively recommend:

TENTATIVE RECOMMENDATION 3:

That an ongoing educational programme be implemented, aimed at increasing public awareness of organ transplantation and medical research, informing the public about the donation process, and encouraging the public to record and make known their wishes to donate organs.

As indicated earlier, we strongly support the continued inclusion of an organ donation card with a Manitoba driver's licence. However, we are concerned that the form which at present appears on the reverse side of the driver's licence is ambiguous. It provides for consent under *"The Human Tissue Act"* for the donation of "my body" or "the following specified parts of my body." However, *"The Human Tissue Act"* only regulates the removal and use of body parts. The donation of *whole* bodies for the purposes of anatomical or other scientific instruction is governed by *"The Anatomy Act"*.[35]

It has been brought to our attention that uncertainty exists at present as to whether a person who indicates on his driver's licence a wish to donate his "body" is authorizing the use of *any part* of his body under *"The Human Tissue Act"* or authorizing the donation of his *whole* body to the Department of Anatomy under the *"The Anatomy Act"*.[36]

We agree that the present donation provisions found on the reverse side of Manitoba driver's licences are ambiguous and inconsistent with the existing legislation. We believe that these provisions should be clarified.

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[35]*"The Anatomy Act"*, C.C.S.M. c. A80.

[36]Dr. Peter Markesteyn, Chief Medical Examiner for Manitoba, telephone discussion, January, 1985; Ms. Del Johnston, Transplant Co-ordinator, Health Sciences Centre, Winnipeg, telephone discussion, January, 1985.

Accordingly, we tentatively recommend:

TENTATIVE RECOMMENDATION 4:

That the organ donation form on the Manitoba driver's licence be amended to be similar to the following:

IF YOU WISH TO DONATE YOUR BODY OR PART OF YOUR BODY FOR USE FOR HUMANITARIAN PURPOSES AFTER DEATH, PLEASE COMPLETE THE FORM BELOW.

I, _____,
HAVING ATTAINED THE AGE OF 18, CONSENT TO THE USE, AFTER MY DEATH, OF
(Check Appropriate Box)

a) ☐ ANY NEEDED ORGANS OR PARTS OF MY BODY; or

☐ THE FOLLOWING SPECIFIED PARTS OF MY BODY, NAMELY_____;

FOR (Strike Out Purposes Not In Accordance With Your Wishes)

TRANSPLANT AND OTHER THERAPEUTIC PURPOSES/
MEDICAL EDUCATION PURPOSES/
MEDICAL RESEARCH PURPOSES.

OR

b) ☐ MY WHOLE BODY FOR PURPOSES OF ANATOMICAL OR OTHER SCIENTIFIC INSTRUCTION OR REQUIREMENTS.

_____ _____
Signature Date

We are also of the view that an information brochure should be sent out with driver's licence renewal applications. This would constitute one aspect of the ongoing educational programme referred to in Recommendation 3. As well, it would serve to assist persons in making an informed decision when filling out the organ donation form attached to the licence. We therefore further recommend:

TENTATIVE RECOMMENDATION 5:

That a pamphlet be distributed with the application for renewal of a driver's licence, including information respecting such matters as

- *the need for bodies and body parts;*
- *the organs and tissue for which there is a particular demand;*
- *the procedure for the declaration of death (see Recommendation 14);*
- *the various options presented on the donor form;*
- *the importance of informing close family members of one's wish to make a post-mortem donation.*

B. Donor Identification: A Central Registry?

It has been suggested that the supply of available human tissue would increase in Manitoba if there were established a central computerized register of willing donors. Such a system could record whether a person had consented to the donation of his body parts and possibly provide a medical profile to facilitate their post-mortem use. The register could then be consulted following the deaths of suitable donors to determine if they had previously recorded their consent. If so, transplantation could begin immediately; if not, the consent of the next of kin would be required.

The Commission has considered whether a donor registry system should be recommended in Manitoba. It is our tentative view that a registry of donors should *not* be established at this time. Our reasons for not favouring its establishment are essentially three-fold.

Our first concern pertains to the effectiveness of such a register. To be truly effective, the register would have to function 24 hours a day, every day, and provide up-to-date information to ensure its continuing accuracy. Not only would this require a large effort; it would also be very expensive. The cost could perhaps be justified if the register would significantly increase the supply of human tissue. This, however, leads to our second concern. The donation of human tissue in Manitoba is derived largely through the consent of the next of kin. Medical personnel appear unwilling to act on the direction of the donor alone; consent from the family is also sought. Given this practice, we question whether an organ donor registry would lead to an increase in the donation rate. Our third and final reason for tentatively rejecting the establishment of a central registry is that we think that it might possibly have the effect of *reducing* the supply of human tissue in this province. We have arrived at this conclusion because of statistics taken in the prairie provinces which show that, although a majority would be willing to sign a donor card, less than one-quarter of those surveyed had actually done so.[37] Although this suggests that many of those who would not record their consent in a registry would nevertheless be willing to have their body parts donated, their next of kin might think otherwise. That is, they might think that the deceased's failure to record his consent in the 'official' register was tantamount to the deceased's rejection of the idea of organ donation. This could falsely influence their decision against donating his body parts. For these reasons, we tentatively recommend:

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[37]Ontario Minister's Task Force on Kidney Donation, Preliminary Report of the Donation Process Subcommittee (December, 1984), Appendices 4 & 6A (W.J.S. Marshall, M.D. and M.A. Robinette, M.D., Subcommittee Co-Chairmen). The 1983 Gallup Poll indicated that while 60 percent of the population in the prairie provinces would be willing to sign a donor card for transplant services, only 23 percent had actually signed one. Similarly, a poll conducted in early 1984 in Ontario suggested that although 63 percent of those surveyed indicated a willingness to donate their own kidneys upon death, 72 percent of those surveyed had not signed the vital organ donor card on an Ontario driver's licence.

TENTATIVE RECOMMENDATION 6:

That a donor registry not be established in Manitoba at this time.

We are fortified in this view by the fact that a similar position was reached by the Law Reform Commission of Australia[38] and the Minister's Task Force on Kidney Donation in their preliminary report.[39]

If, at some point in the future, there is a significant increase in the number of persons who sign donor cards, and if medical personnel begin to accept a practice of acting on the direction of the donor, without also seeking familial consent, the establishment of a donor registry should then perhaps be reconsidered.

C. Hospitals and the Medical Profession

In an oral summation of the findings of the Minister's Task Force on Kidney Donation,[40] it was suggested that there exists not a shortage of potential donors but rather a shortage of seekers. One of the solutions offered to increase the supply of needed organs and tissues was quite remarkable in its simplicity: ASK. More specifically, it was suggested that hospitals adopt, as a matter of policy, the practice of 'routine request' in all cases where a potential organ donor is identified.

The 'routine request' approach has received support elsewhere:

> . . . the major obstacle to organ procurement is the failure to ask family members about organ donation.
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> . . . .

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[38]The Law Reform Commission of Australia, *Human Tissue Transplant Report* (Report No. 7, 1977), at 95.

[39]*Supra* n. 37, as modified at the Conference on Organ Donation in the Eighties: A Blueprint for Success, *infra* n. 40.

[40]Ontario Minister's Task Force on Kidney Donation, *Preliminary Report of the Donation Process Subcommittee, supra* n. 37, presented at the Conference on Organ Donation in the Eighties: A Blueprint for Success, Toronto, December 2-4, 1984, sponsored by the Ontario Ministry of Health.

> Physicians, nurses, or other hospital personnel should be required to inquire whether available family members will give their consent to organ donation. . . . [H]ospital accreditation requirements could be revised to include a provision mandating that at death the families of potential donors be approached about their willingness to consent.[41]

We are aware of one programme of routine request with respect to eye donation which was adopted on a provisional basis in Edmonton, Alberta in August, 1984 by the office of the Chief Medical Examiner.[42] We find the

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[41]Arthur L. Caplan, *supra* n. 19, at 12.

[42]Dr. John Butt, Chief Medical Examiner, Province of Alberta, telephone interview, January, 1985. Prior to this, the office had practised a passive approach to organ donation: tissues were retained during the performance of an autopsy for purposes of donation only when it was brought to the attention of the medical examiner that the deceased or his family wished to donate body parts (except, of course, with respect to the removal of the pituitary gland pursuant to the *Fatality Inquiries Act*, R.S.A. 1980, c. F-6, s. 27).

The intention to commence the practice of routine request for consent to eye donation was first announced through the media so that the public would be aware of the new procedure.

Bodies which arrive at the medical examiner's office for post-mortem examination are assessed for suitability for eye donation. The critical factors are (a) age (between the age of 4 to 60 years); (b) time of death (known to be within preceding six hours); and (c) absence of certain medical conditions contra-indicating eye donation. If the deceased is determined to be suitable as an eye donor, a member of the investigative staff contacts the deceased's family. Eye donation is discussed in a tactful and positive manner, and the family is given the opportunity to make an educated and informed consent. Where the request is made in person, a consent form is signed; if over the telephone, the conversation is recorded.

We have been advised that approximately 10 percent of the deceased persons upon whom official autopsies are performed are assessed to be suitable eye donors, and in approximately 45 percent of these cases, consent for eye donation is given by the families. Statistics forwarded to us indicate that, as of the end of January, 1985, twenty pairs of eyes had been obtained under this programme.

It is our understanding that the staff involved in making the requests had initially anticipated some discomfort in approaching the families at such a difficult time. However, the experience has proved to be positive; families are not repulsed by being asked to consider eye donation, and no criticism has been voiced by the families or the media. Plans are now underway for extending the programme to Calgary, Alberta.

results of the Alberta programme most encouraging, and believe the programme provides a good example of the success which can be achieved through the adoption of a policy of routine request.[43]

Earlier in this paper, we had discussed the understandable reluctance and discomfort felt by members of the medical profession in approaching families in their time of grief to seek consent to organ donation. However, we believe it important for hospital personnel to view the discussion of organ donation not as imposing a burden upon the family, but as providing them with the opportunity to participate in a rewarding experience, "to transform the tragedy of death into the gift of life."[44]

> Physicians appear to be largely unaware of the comfort that organ donation brings to the family months and years after the death. Family members rarely regret their decision to permit removal of organs. They frequently relate that the loved one was "a generous person and would have wanted it that way." Also, family members find comfort in knowing that part of their loved one still survives to

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[43]Dr. Peter Markesteyn (Chief Medical Examiner for Manitoba, telephone interview, January 1985) has expressed to us his strong support of the Alberta approach. Unfortunately, the staffing in Manitoba is not sufficient to allow for the adoption of a routine request programme in this province at this time. However, whenever possible, the office of the medical examiner does notify a representative from the Eye Bank if a suitable donor is identified. Personnel from the Eye Bank may then contact the deceased's family to seek consent for eye donation. We offer our support and encouragement for the continuation of this practice.

[44]Arthur L. Caplan, *supra* n. 19, at 192.
We have been deeply touched by two personal accounts related to us involving parents who recently suffered the tragic loss of a child. In neither case were the parents asked if they wished to donate their deceased's child's organs. Both parents have since conveyed a deep sense of regret, and a feeling of having been deprived of a rare opportunity to make a precious gift, to perhaps have relieved the suffering of someone else's child. Being approached for consent to donation would not have been viewed as a tasteless intrusion, but rather as a welcome chance to make some good come from the tragedy of death.

> "help" someone else. Physicians, nurses, chaplains, and social workers need not feel apologetic about discussing organ donation with the family.[45](footnotes deleted)

We are of the view that the adoption of a policy of routinely requesting consent from potential donors' families is fundamental in achieving the goal of increasing the supply of donated human tissue. The appropriate person to seek consent in a hospital (e.g., attending physician, ICU nurse, hospital chaplain) or in a medical examiner's office (e.g., investigative officer), could be determined by the individual hospital or office. Staff should be encouraged to present organ donation as a positive and rewarding option. Accordingly, we recommend:

TENTATIVE RECOMMENDATION 7:

That a policy of routine request be adopted by hospitals, and by offices in which post-mortem examinations are conducted, to be followed whenever a suitable candidate for organ donation is identified and the prospective donor is not known to have either consented or objected to the post-mortem donation of his organs and tissue.

As well, we believe that other steps can be taken by hospitals and the medical profession to reduce the medical barriers within the organ donation process which we discussed in Chapter 2 of this paper. We therefore tentatively recommend:[46]

TENTATIVE RECOMMENDATION 8:

That consideration be given by members of the medical profession, hospital administrators, hospital and medical associations, organ procurement agencies, and government agencies involved in both

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[45]F.P. Stuart, "Need, Supply, and Legal Issues Related to Organ Transplantation in the United States" (1984), 16 Transplantation Proceedings 87 at 89-90.

[46]Many of our suggestions herein are based on the preliminary findings and conclusions of the Ontario Minister's Task Force on Kidney Donation (C.R. Stiller, M.D. and M.A. Robinette, M.D., Co-Chairmen). We gratefully acknowledge our indebtedness to them. We are aware that similar recommendations have been advanced recently by the Transplant Program at the Health Sciences Centre in Winnipeg.

hospital administration and the provision of medical services to the following suggestions:

- *Every hospital should establish or adopt*

    - *an Organ Donation Committee to implement policies and guidelines respecting the initiation and execution of the organ donation process;*
    - *an individual or team responsible for co-ordinating organ donation within the hospital;*
    - *guidelines and criteria for the identification of suitable organ donors;*
    - *guidelines for the diagnosis of brain death;*
    - *a policy respecting organ donation pursuant to the consent and direction of the donor himself. The family should be informed of the deceased's express wishes, but not given the opportunity to countermand his directions;*
    - *guidelines for organ retrieval and donor maintenance;*
    - *guidelines for effective methods of organ storage.*

- *The above policies and guidelines should be developed by the hospital Organ Donation Committee in conjunction with provincial hospital and medical associations, and The Manitoba Organ Procurement Committee. Appropriate modifications may be required for small hospitals and hospitals with no Intensive Care Unit.*

- *The establishment of guidelines and criteria for organ donation within a hospital should be made a necessary requirement for hospital accreditation.*

- *Physicians should receive remuneration for time spent identifying potential organ donors, declaring brain death, obtaining consent to donation and maintaining organ donors.*

- *Hospitals should be reimbursed for expenses involved in donor maintenance and transportation.*

- *Families of organ donors should be reimbursed for any costs incurred by them in relation to the donation process.*

- *Regional hospitals capable of donor support should be clearly identified.*

- *A specialized team should be available to travel to hospitals to declare brain death when required.*

- *An organ retrieval team should be available to travel to hospitals when required.*

- *A 24-hour telephone advice service should be provided for hospitals seeking information or assistance respecting the organ donation process.*

- *A transportation system for the rapid and efficient transport of donors, retrieval teams and organs should be developed.*

- *Hospital personnel who participated in procuring an organ for transplantation should be given recognition for their efforts and provided with feedback as to the outcome of the organ transplant.*

- *A provincial body responsible for co-ordinating organ retrieval and distribution within the province, and co-ordinating activities with other jurisdictions, should be funded and supported.*

- *Medical schools, nursing schools and professional associations should provide educational programmes*

    - *to make physicians and nurses aware of organ transplantation and medical research, the critical shortage of organs, and the important role of medical staff in the organ donation process;*
    - *to encourage a positive attitude in medical professionals toward organ donation;*
    - *to educate medical professionals in the identification of suitable organ donors and the procedures involved in the declaration of brain death;*
    - *to instill within physicians a sense of ethical obligation and professional responsibility to consider organ donation at the time of death of one of their patients.*

III. RECOMMENDATIONS FOR LEGISLATIVE CHANGE

Although we have recommended that the basic scheme of our present legislation be maintained, there are several ancillary legislative changes which we believe would be desirable. Some of these involve a modification of existing provisions; others involve matters which are at present unaddressed by the Act.

A. Consent of Family Members

At present, in circumstances in which the deceased has not provided for the donation of his body parts, consent may be given by a family member either after the donor's death[47] or where death is imminent.[48] The Act contains a priorized list of persons who may give such consent:

> (a) [the deceased's] spouse; or
> (b) if none, any one of his children eighteen years of age or over; or
> (c) if none, either of his parents; or
> (d) if none, any one of his brothers or sisters eighteen years of age or over.

With respect to consent sought *after* the donor's death, there is also added, after the provision respecting brothers and sisters:

> (e) if none, the person lawfully in possession of the body or the Inspector of Anatomy appointed under The Anatomy Act.

As noted earlier in this paper, the "person lawfully in possession of the body" may in some cases be a hospital.

It is only possible to move down the priorized list where there exists no person in a previous category. For example, consent can only be given by an adult child if the deceased had no spouse. If there is a spouse, even if the spouse is unavailable, organ donation cannot be authorized by any family member from the subsequent categories.

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[47] "*The Human Tissue Act*", C.C.S.M. c. H180, s. 3(1).

[48] "*The Human Tissue Act*", C.C.S.M. c. H180, s. 3(2).

The *Uniform Human Tissue Gift Act*[49] (attached herein as Appendix B) deals with the problem of unavailable family members by allowing for consent to be given by a member of a class of relatives where there is no member of a preceding class or where there is a member of a preceding class but that person is "not readily available".

We are of the view that it would be desirable to allow for consent to be given by the closest living relative who is available to give consent. Accordingly we tentatively recommend:

TENTATIVE RECOMMENDATION 9:

That the first four clauses of s. 3(1) and the four clauses of s. 3(2) of "The Human Tissue Act" be amended to read in a manner similar to the following:

(a) his spouse; or
(b) if none or if his spouse is not readily available, any one of his children eighteen years of age or over; or
(c) if none or if none is readily available, either of his parents; or
(d) if none or if neither is readily available, any one of his brothers or sisters eighteen years of age or over;

At present, the Act provides in s. 3(3)(a) that no person shall act upon a direction given by a family member if he has actual knowledge that another member of the same class of persons as the person who gave the direction objects thereto. In light of Recommendation 9, this provision requires minor amendment to prohibit action where there is actual knowledge that a member of the same class as the person who gave consent objects or where there is actual knowledge that a member of a prior class (who was not readily available) objects thereto. We therefore tentatively recommend:

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[49]Conference of Commissioners on Uniformity of Legislation in Canada, *Proceedings of the Fifty-third Annual Meeting* (August, 1971) at 76 and 152. This Uniform Act has been adopted by all the common law provinces, except Manitoba and New Brunswick, with some minor variations.

TENTATIVE RECOMMENDATION 10:

That s. 3(3)(a) of "The Human Tissue Act" be amended to read in a manner similar to the following:

> *(a) shall not act upon the direction if he has actual knowledge that a person of the same or closer relationship to the deceased person than the person who gave the direction objects thereto.*

We invite your views on the following outstanding issues:

(a) *Should a common law spouse be authorized to give consent to organ removal? If so, how should a common law spouse be defined?*[50]

(b) *Should a separated spouse continue to be able to give consent to organ donation?*[51]

(c) *Should the list of persons authorized to give consent be expanded to include*

- *"any other of his next of kin eighteen years of age or over", as a class of persons after adult brothers and sisters?*[52]
- *"his legal guardian" as part of the class of "parents"?*

(d) *Where relatives do exist but are not readily available, should "the person lawfully in possession of the body or*

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[50]*See e.g., Fatality Inquiries Act*, R.S.A. 1980, c. F-6, s. 1(e) which reads as follows: "'common law spouse' means, with reference to a deceased person, a man or woman who, although not legally married to the deceased, lived and cohabited with the deceased immediately prior to the deceased's death as the deceased's spouse and was known as such in the community in which they lived".

[51]*See e.g., The Human Tissue Gift Act*, R.S.S. 1978, c. H-15, s. 6(1) which allows for a spouse to give consent "unless immediately prior to the death or injury or illness of the person, that person and his spouse were living separate and apart from each other".

[52]*See e.g.*, s. 5(1)(e) of the *Uniform Human Tissue Gift Act*, *supra* n. 49.

> *the Inspector of Anatomy appointed under The Anatomy Act" be authorized to consent after the donor's death to tissue removal? In some circumstances, this would allow the administrative head of the hospital to give permission for organ donation where family members do exist but are not readily available.*[53]

Our present Act does not expressly prohibit a family member from giving consent to organ donation where he has reason to believe that the person who died or whose death is imminent would have objected thereto. The 1971 *Uniform Human Tissue Gift Act* does contain such a prohibition. Because we are of the view that the wishes of the deceased should always be paramount, we tentatively recommend:

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[53]*See e.g.*, s. 5(1) of the *Uniform Human Tissue Act* of 1970 (Conference of Commissioners on Uniformity of Legislation in Canada, *Proceedings of the Fifty-second Annual Meeting* (August, 1970), at 36 and 151) which reads in part as follows:

> . . .
> (c) if none or if none is readily available, either of his parents; or
> (d) if none or if neither is readily available, any one of his brothers or sisters who has attained the age of majority; or
> (e) if none or if none is readily available, any other of his next of kin who has attained the age of majority; or
> *(f) if none or if none is readily available, the person lawfully in possession of the body other than, where he died in hospital, the administrative head of the hospital; or*
> *(g) if none or if none is readily available and he died in hospital, the administrative head of the hospital,*
>
> may consent, . . . (emphasis added)

This is similar to the provision which is in force in Newfoundland: *The Human Tissue Act*, S.N. 1971, no. 66, s. 8(1).

However, the 1970 Uniform Act was changed in 1971 (*supra* n. 49) to exclude the administrative head of a hospital as a person who could consent to organ donation. The majority of the common law provinces have followed the 1971 Uniform Act in this regard.

TENTATIVE RECOMMENDATION 11:

That "The Human Tissue Act" be amended expressly to prohibit a person from making a direction under s. 3(1) or s. 3(2) if he has reason to believe that the person who died or whose death is imminent would have objected thereto.

At present, our Act does not provide for the form of consent given by family members. In Saskatchewan,[54] for example, provision is made for written, oral or mechanically-recorded consent. We believe such clarity is desirable and therefore tentatively recommend:

TENTATIVE RECOMMENDATION 12:

That it be provided that a direction given under s. 3(1) or s. 3(2) of "The Human Tissue Act" may be

- *in a writing signed by the spouse, relative or other person; or*
- *orally by the spouse, relative or other person in the presence of at least two witnesses; or*
- *by the telegraphic, recorded telephonic, or other recorded message of the spouse, relative or other person; or*
- *by a telephonic message received and heard by two persons from the spouse, relative or other person where the two persons subsequently record in writing the nature and contents of the direction.*

B. Requirement of Consent by Medical Examiner

Prior to 1978, s. 2(2)(b) of *"The Human Tissue Act"* (dealing with donation pursuant to the direction of the donor) and s. 3(3)(c)(dealing with donation pursuant to the direction of the donor's family) both provided that a person could not act upon a direction for donation without the consent of a medical examiner "if he has reason to believe that an inquest may be required

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[54]*The Human Tissue Gift Act*, R.S.S. 1978, c. H-15, s. 6(1).

to be held upon the body." In 1978, s. 3(3)(c) was amended to read "if he has reason to believe that an *inquiry or investigation may be required to be held respecting the cause and manner of death*."[55] (emphasis added) Section 2(2)(b) was not similarly amended.

The reference in s. 3(3)(c) to an "inquiry or investigation" is somewhat wider than the reference in s. 2(2)(b) to an "inquest."[56] We see no reason for maintaining this distinction. Accordingly we tentatively recommend:

TENTATIVE RECOMMENDATION 13:

That s. 2(2)(b) of "The Human Tissue Act" be amended to read as follows:

> *(b) shall not, except with the consent of the medical examiner or chief medical examiner appointed under The Fatality Inquiries Act, act upon a direction if he has reason to believe that an inquiry or investigation may be required to be held respecting the cause and manner of death.*

C. Procedure for Declaration of Death

Section 7 of the *Uniform Human Tissue Gift Act*[57] provides as follows:

> 7. (1) For the purposes of a post-mortem transplant, the fact of death shall be determined by at least two physicians in accordance with accepted medical practice.
>
> (2) No physician who has had any association with the proposed recipient that might influence his judgment shall take any part in the determination of the fact of death of the donor.
>
> (3) No physician who took any part in the determination of the fact of death of the donor shall participate in any way in the transplant procedures.

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[55] *"The Statute Law Amendment Act (1978)"*, S.M. 1978, c. 49, s. 55.

[56] *See "The Fatality Inquiries Act"*, C.C.S.M. c. F52, *esp.* s. 6(1) and s. 6(4).

[57] *Supra*, n. 49.

> (4) Nothing in this section in any way affects a physician in the removal of eyes for cornea transplants.

There is no similar stipulation in Manitoba's human tissue legislation.

However, Manitoba has statutorily defined the death of a person as taking place "at the time at which irreversible cessation of all that person's brain function occurs."[58] The College of Physicians and Surgeons of Manitoba has identified the criteria for brain death, and has stipulated that

> . . . determination of death should be made by the attending physician and by a consultant familiar with the diagnosis and treatment of coma. The decision should not be made by a member of an organ transplant team.[59]

This stipulation closely parallels the above-quoted provision of the *Uniform Human Tissue Gift Act*.

Transplantation of vital organs such as the heart or kidney requires removal of the organ immediately following the death of the donor.[60] Concern might be felt by some members of the public that efforts to save a potential donor's life may perhaps be compromised in the interests of procuring an organ for transplant purposes.

Public anxiety created by the fear that organs may be removed prematurely obviously has an adverse effect on the public's willingness to donate body parts for transplant purposes. It is important to allay that anxiety by statutorily ensuring that the life of a potential donor is adequately protected. We accordingly tentatively recommend:

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[58]"*The Vital Statistics Act*", C.C.S.M. c. V60, s. 2.

[59]The College of Physicians and Surgeons of Manitoba, "Brain Death Protocol", January 26, 1983.

[60]The same is not true of cornea, skin and bone which remain suitable for donation for some hours after the donor's death.

TENTATIVE RECOMMENDATION 14:

That "The Human Tissue Act" provide that for the purposes of a post-mortem transplant, other than a corneal, bone, or skin graft, the fact of death shall be determined by at least two physicians, neither of whom have had any association with the proposed recipient that might influence his judgment. No physician who takes part in the determination of the fact of death of the donor shall be permitted to participate in any way in the transplant proceedings.

D. Protection from Civil Liability

We noted earlier in this paper that a significant percentage of medical professionals appear to regard questions of legal responsibility as constituting a barrier to involvement in the donation process.[61]

It is provided in the *Uniform Human Tissue Gift Act*[62] that:

> 9. No action or other proceeding for damages lies against any person for any act done in good faith and without negligence in the exercise or intended exercise of any authority conferred by this Act.

We believe the adoption of such a provision may serve to encourage medical professionals to participate in the organ donation process and to allay fears of incurring civil liability for following in good faith the human tissue legislation. We therefore tentatively recommend:

TENTATIVE RECOMMENDATION 15:

That "The Human Tissue Act" provide that no action or other proceeding lies against any person for any act done in good faith and without negligence in the exercise or intended exercise of any authority conferred by the Act.

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[61]Minister's Task Force on Kidney Donation, *supra* n. 17, at 19.

[62]Section 9, *supra* n. 49.

E. Prohibition of Sale

Earlier in this paper, we considered and rejected the adoption of a system of human tissue procurement involving the sale of body parts. We noted at that time that *"The Human Tissue Act"* does not at present expressly prohibit the sale of cadaver parts for valuable consideration.

Under the common law, which recognizes no property in a dead body,[63] it would not be possible to make a valid contract for the sale and purchase of body parts. This in itself does not, however, make the sale of body parts otherwise unlawful.

We are of the view that trade in body parts for valuable consideration is contrary to public policy and otherwise undesirable for reasons previously mentioned in this paper. We note that the 1971 *Uniform Human Tissue Gift Act* makes it unlawful to buy, sell or deal in for valuable consideration body parts.[64] We are also aware that The Canadian Medical Association Board of Directors approved the following resolution at a meeting on December 1, 1984:

> Whereas the practice of trafficking in human body parts is abhorrent and contrary to the public interest,
>
> Be it resolved that the provincial health ministries be approached to consider appropriate legislation (where required) to prohibit the sale, transfer or disposal for personal gain of human tissues (renewable and non-renewable) and organs for the purpose of human transplantation.

We therefore tentatively recommend:

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[63] *Williams* v. *Williams* (1882), 20 Ch. D. 659.

[64] Section 10, *supra* n. 49. There are some exceptions listed in s. 10 which are not of present concern.

TENTATIVE RECOMMENDATION 16:

> *That "The Human Tissue Act" prohibit the sale or purchase of, or other dealing for valuable consideration in, any human cadaveric body parts for therapeutic purposes, medical education or medical research, and declare any such dealing to be invalid as contrary to public policy.*

TENTATIVE RECOMMENDATION 17:

> *That "The Human Tissue Act" further provide that every person who knowingly contravenes any of its provisions is guilty of an offence and liable, on summary conviction, to a fine or imprisonment or both.*

F. Inter Vivos Procurement of Tissue

We stated at the outset of this Working Paper that *"The Human Tissue Act"* regulates the removal and use of tissue and organs after the death of the donor. It does not regulate the donation of human tissue *inter vivos* - that is, by living persons. There is no comprehensive legislation dealing with the issue of *inter vivos* donations in Manitoba. What rules should apply, for example, where a person wishes to donate a kidney to save or improve the life of his sibling?

The subject of *inter vivos* gifting of human tissue raises very difficult and complex questions. In the case of post-mortem donation, the donor's death is certified by two physicians before organ removal takes place. Consequently, there is complete assurance that the organ removal poses no risk to the donor's well-being. No similar assurance exists with respect to *inter vivos* gifting at least in regard to non-regenerative tissue.[65] It is fundamental, therefore, that the law ensure, at the very least, that a person who wishes to donate non-regenerative tissue fully understands the risks attendant with its removal.

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[65]Human tissue which is regenerative includes such things as skin, bone, blood, blood constituent and sperm.

Due to limitations of time and resources, we have yet to give sufficient study to the topic of *inter vivos* gifting. Accordingly, no tentative recommendations are included in this Working Paper on this subject. We would, however, welcome comments on what provisions, if any, should exist to regulate the donation of human tissue by living donors. To assist in this regard, we set forth the following specific questions to which we would invite response:

(a) *Should the law allow an <u>adult</u> person the right to have non-regenerative tissue removed from his body for implantation in the body of another living person? If so, under what circumstances?*

> *We note that section 3 of the "Uniform Act" allows an adult person to consent in writing to the removal of human tissue where that person "is able to make a free and informed decision." The text of subsection 3(1) is as follows:*
>
> *3.(1) Any person who has attained the age of majority, is mentally competent to consent, and is able to make a free and informed decision may in a writing signed by him consent to the removal forthwith from his body of the tissue specified in the consent and its implantation in the body of another living person.*
>
> *"Tissue" is defined in paragraph 1(c) of the Uniform Act to exclude essentially regenerative tissue.*

(b) *Should the law allow a <u>minor</u> the right described in question (a)? If so, under what circumstances? Should the parents of a minor ever be allowed to consent on his behalf?*

> *The Uniform Act prohibits a minor from donating non-regenerative tissue. However, it protects any person who acted upon the minor's consent if that person had no reason to believe that the minor was under the age of majority (s. 3(2)).*

(c) *Should the law ever allow a mentally incompetent person, whether adult or not, to donate human tissue during his lifetime?*

> *We note on this point that the Law Reform Commission of Australia recommended that it should not ever be lawful to take human tissue from the mentally incompetent.*[66] *Similarly, the Uniform Act prohibits a mentally incompetent person from donating non-regenerative tissue. Again, however, it protects any person who acted upon that consent if he had no reason to believe that the donor was mentally incompetent.*

Whatever general provisions are eventually made concerning the donation of human tissue by living persons, we are of the view that these provisions should exclude from their ambit the transplantation of reproductive organs and tissue. This would exclude in particular the transfer of embryos, the removal and transplantation of testicles and ovaries and the use of ova and sperm. These matters of genetic engineering require separate study and analysis. We are aware that the Ontario Law Reform Commission intends to report on the subject of human artificial insemination and related matters in the near future.

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[66]*Supra* n. 38, at 51.

CHAPTER 4

SUMMARY OF TENTATIVE RECOMMENDATIONS

The tentative recommendations of the Commission are as follows:

1. That, subject to Recommendation 2, the requirement of consent to remove human tissue after death for therapeutic, educational and research purposes be retained. (p. 36)

2. That the presumed consent provisions in s. 6 of "The Human Tissue Act" not be extended to permit the removal and retention of organs or tissue other than the pituitary gland. (p. 42)

3. That an ongoing educational programme be implemented, aimed at increasing public awareness of organ transplantation and medical research, informing the public about the donation process, and encouraging the public to record and make known their wishes to donate organs. (p. 45)

4. That the organ donation form on the Manitoba driver's licence be amended to be similar to that on Page 46 of this Paper. (p. 46)

5. That a pamphlet be distributed with the application for renewal of a driver's licence, including information respecting such matters as

- the need for bodies and body parts;
- the organs and tissue for which there is a particular demand;
- the procedure for the declaration of death (see Recommendation 14);
- the various options presented on the donor form;
- the importance of informing close family members of one's wish to make a post-mortem donation. (p. 47)

6. That a donor registry not be established in Manitoba at this time. (p. 49)

7. That a policy of routine request be adopted by hospitals, and by offices in which post-mortem examinations are conducted, to be followed whenever a suitable candidate for organ donation is identified and the prospective donor is not known to have either consented or objected to the post-mortem donation of his organs and tissue. (p. 52)

8. That consideration be given by members of the medical profession, hospital administrators, hospital and medical associations, organ procurement agencies, and government agencies involved in both hospital administration and the provision of medical services to the following suggestions:

- Every hospital should establish or adopt

    - an Organ Donation Committee to implement policies and guidelines respecting the initiation and execution of the organ donation process;
    - an individual or team responsible for co-ordinating organ donation within the hospital;
    - guidelines and criteria for the identification of suitable organ donors;
    - guidelines for the diagnosis of brain death;
    - a policy respecting organ donation pursuant to the consent and direction of the donor himself. The family should be informed of the deceased's express wishes, but not given the opportunity to countermand his directions;
    - guidelines for organ retrieval and donor maintenance;
    - guidelines for effective methods of organ storage.

- The above policies and guidelines should be developed by the hospital Organ Donation Committee in conjunction with provincial hospital and medical associations, and The Manitoba Organ Procurement Committee. Appropriate modifications may be required for small hospitals and hospitals with no Intensive Care Unit.

- The establishment of guidelines and criteria for organ donation within a hospital should be made a necessary requirement for hospital accreditation.

- Physicians should receive remuneration for time spent identifying potential organ donors, declaring brain death, obtaining consent to donation and maintaining organ donors.

- Hospitals should be reimbursed for expenses involved in donor maintenance and transportation.

- Families of organ donors should be reimbursed for any costs incurred by them in relation to the donation process.

- Regional hospitals capable of donor support should be clearly identified.

- A specialized team should be available to travel to hospitals to declare brain death when required.

- An organ retrieval team should be available to travel to hospitals when required.

- A 24-hour telephone advice service should be provided for hospitals seeking information or assistance respecting the organ donation process.

- A transportation system for the rapid and efficient transport of donors, retrieval teams and organs should be developed.

- Hospital personnel who participated in procuring an organ for transplantation should be given recognition for their efforts and provided with feedback as to the outcome of the organ transplant.

- A provincial body responsible for co-ordinating organ retrieval and distribution within the province, and co-ordinating activities with other jurisdictions, should be funded and supported.

- Medical schools, nursing schools and professional associations should provide educational programmes

    - to make physicians and nurses aware of organ transplantation and medical research, the critical shortage of organs, and the important role of medical staff in the organ donation process;
    - to encourage a positive attitude in medical professionals toward organ donation;
    - to educate medical professionals in the identification of suitable organ donors and the procedures involved in the declaration of brain death;
    - to instill within physicians a sense of ethical obligation and professional responsibility to consider organ donation at the time of death of one of their patients. (p. 52)

9. That the first four clauses of s. 3(1) and the four clauses of s. 3(2) of "The Human Tissue Act" be amended to read in a manner similar to the following:

    (a) his spouse; or
    (b) if none or if his spouse is not readily available, any one of his children eighteen years of age or over; or
    (c) if none or if none is readily available, either of his parents; or

(d) if none or if neither is readily available, any one of his brothers or sisters eighteen years of age or over; (p. 56)

10. That s. 3(3)(a) of "The Human Tissue Act" be amended to read in a manner similar to the following:

(a) shall not act upon the direction if he has actual knowledge that a person of the same or closer relationship to the deceased person than the person who gave the direction objects thereto. (p. 57)

11. That "*The Human Tissue Act*" be amended expressly to prohibit a person from making a direction under s. 3(1) or s. 3(2) if he has reason to believe that the person who died or whose death is imminent would have objected thereto. (p. 59)

12. That it be provided that a direction given under s. 3(1) or s. 3(2) of "The Human Tissue Act" may be

- in a writing signed by the spouse, relative or other person; or
- orally by the spouse, relative or other person in the presence of at least two witnesses; or
- by the telegraphic, recorded telephonic, or other recorded message of the spouse, relative or other person; or
- by a telephonic message received and heard by two persons from the spouse, relative or other person where the two persons subsequently record in writing the nature and contents of the direction. (p. 59)

13. That s. 2(2)(b) of "The Human Tissue Act" be amended to read as follows:

(b) shall not, except with the consent of the medical examiner or chief medical examiner appointed under The Fatality Inquiries Act, act upon a direction if he has reason to believe that an inquiry or investigation may be required to be held respecting the cause and manner of death. (p. 60)

14. That "The Human Tissue Act" provide that for the purposes of a post-mortem transplant, other than a corneal, bone, or skin graft, the fact of death shall be determined by at least two physicians, neither of whom have had any association with the proposed recipient that might influence his judgment. No physician who takes part in the determination of the fact of death of the donor shall be permitted to participate in any way in the transplant proceedings. (p. 62)

15. That "The Human Tissue Act" provide that no action or other proceeding lies against any person for any act done in good faith and without negligence in the exercise or intended exercise of any authority conferred by the Act. (p. 62)

16. That "The Human Tissue Act" prohibit the sale or purchase of, or other dealing for valuable consideration in, any human cadaveric body parts for therapeutic purposes, medical education or medical research, and declare any such dealing to be invalid as contrary to public policy. (p. 64)

17. That "The Human Tissue Act" further provide that every person who knowingly contravenes any of its provisions is guilty of an offence and liable, on summary conviction, to a fine or imprisonment or both. (p. 64)

CHAPTER 5

SUMMARY OF QUESTIONS OUTSTANDING

Life-saving Emergency (pp. 36-38)

(a) Is it necessary or desirable to include in our human tissue legislation a provision dispensing with the need for consent to organ removal when two physicians attest in writing to the impossibility of contacting the spouse or other designated relative in due time to obtain consent, the urgency of the proposed transplant operation and the serious hope of saving a human life?

(b) In the above-described circumstances, would physicians in Manitoba feel comfortable making such a written attestation or engaging in organ removal or transplantation pursuant thereto?

Consent of Family Members (pp. 55-58)

(a) Should a common law spouse be authorized to give consent to organ removal? If so, how should a common law spouse be defined?

(b) Should a separated spouse continue to be able to give consent to organ donation?

(c) Should the list of persons authorized to give consent be expanded to include

- "any other of his next of kin eighteen years of age or over", as a class of persons after adult brothers and sisters?

- "his legal guardian" as part of the class of "parents"?

(d) Where relatives do exist but are not readily available, should "the person lawfully in possession of the body or the Inspector of Anatomy appointed under The Anatomy Act" be authorized to consent after the donor's death to tissue removal?

Inter Vivos Procurement of Tissue (pp. 64-66)

(a) Should the law allow an adult person the right to have non-regenerative tissue removed from his body for implantation in the body of another living person? If so, under what circumstances?

(b) Should the law allow a minor the right described in question (a)? If so, under what circumstances? Should the parents of a minor ever be allowed to consent on his behalf?

(c) Should the law ever allow a mentally incompetent person, whether adult or not, to donate human tissue during his lifetime?

APPENDIX A

CHAPTER H180

THE HUMAN TISSUE ACT.

HER MAJESTY, by and with the advice and consent of the Legislative Assembly of Manitoba, enacts as follows:

Definition.

1 In this Act "person lawfully in possession of the body" does not include

(a) a medical examiner in possession of a body for the purpose of investigation: or

(b) an embalmer or funeral director in possession of a body for the purpose of its burial, cremation, or other disposal.

S.M., 1968, c. 31, s. 1; Am. S.M. 1975, c. 42, s. 27.

Direction by person before death.

2(1) A person eighteen years of age or over may

(a) in writing at any time; or

(b) orally in the presence of at least two witnesses during his last illness;

direct that any part of his body or a specified part of his body may be used after his death for therapeutic purposes or for purposes of medical education or for purposes of medical research.

Effect of direction.

2(2) Upon the death of a person who has given a direction under subsection (1), the direction is full authority for obtaining possession of the body and the removal and use of any part of his body or the specified part of his body, as the case may be, for the purposes specified in the direction, except that a person

(a) shall not act upon a direction if he has reason to believe that the person who gave the direction subsequently withdrew it; and

(b) shall not, except with the consent of a medical examiner or chief medical examiner appointed under the Fatality Inquiries Act, act upon a direction if he has reason to believe that an inquest may be required to be held upon the body.

Am. S.M. 1974, c. 59, s. 33.

Effect of direction given by person under 18.

2(3) A direction given under subsection (1) by a person under eighteen years of age is valid for the purposes of this section if the person who acted upon it had no reason to believe that the person who gave the direction was under eighteen years of age at the time he gave it.

S.M., 1968, c. 31, s. 2; Am. S.M. 1974, c. 59, s. 33.

Direction by next of kin.

3(1) Where a person other than a person who has made a direction under section 2 dies,

(a) his spouse; or
(b) if none, any one of his children eighteen years of age or over; or
(c) if none, either of his parents; or
(d) if none, any one of his brothers or sisters eighteen years of age or over; or
(e) if none, the person lawfully in possession of the body or the Inspector of Anatomy appointed under The Anatomy Act;

may direct that any part of the body or any specified part of the body may be used for therapeutic purposes or for purposes of medical education or for purposes of medical research.

Am. S.M. 1971, c. 82, s. 29; S.M. 1976, c. 69, s. 26.

Direction where death imminent and inevitable.

3(2) Where a person other than a person who has made a direction under section 2 is, in the opinion of a duly qualified medical practitioner, incapable of making such a request and his death is considered by the duly qualified medical practitioner to be imminent,

(a) his spouse; or
(b) if none, any of his children eighteen years of age or over; or
(c) if none, either of his parents; or
(d) if none, any one of his brothers or sisters eighteen years of age or over;

may direct that any part of the body or any specified part of the body may be used for therapeutic purposes or for purposes of medical education or for purposes of medical research.

Am. S.M. 1971, c. 82, s. 29.

Effect of direction.

3(3) Upon the death of a person in respect of whom a direction is given under this section, the direction is full authority for obtaining possession of the body and the removal and use of any part of the body or of the specified part of the body, as the case may be, for the purposes specified in the direction, except that a person

(a) shall not act upon the direction if he has actual knowledge that another member of the same class of persons as the person who gave the direction objects thereto;
(b) shall not act upon the direction if he has reason to believe that the deceased person would, if living, have objected thereto; and
(c) shall not, except with the consent of the medical examiner or chief medical examiner appointed under The Fatality Inquiries Act, act upon a direction if he has reason to believe that an inquiry or investigation may be required to be held respecting the cause and manner of death.

Am. S.M. 1974, c. 59, s. 33; S.M. 1978, c. 49, s. 55.
S.M., 1968, c. 31, s. 3.
Am. S.M. 1971, c. 82, s. 29; S.M. 1974, c. 59, s. 33; S.M. 1976, c. 69, s. 26; S.M. 1978, c. 49, s. 55.

Where parts of body not required.

4(1) Where a direction has been given under this Act for the removal and use of any part of a body or of a specified part of a body for therapeutic purposes or for purposes of medical education or for purposes of medical research, and at the time of or immediately after the death there is no known request for parts of the body, or the specified part of the body, as the case may be, for the purposes set out in the direction, the body shall be dealt with as though no direction under this Act had been given.

Disposal of body after removal of part.

4(2) Where, after death, a part of a body has been removed in accordance with this Act, forthwith after the removal of the part, the body shall be returned to the custody and control of the person who would have had custody and control of the body if no direction had been made under this Act.

S.M., 1968, c. 31, s. 4.

Lawful dealings not affected.

5 Nothing in this Act makes unlawful any dealing with a body of a deceased person or a part thereof that would be lawful if this Act had not been passed.

S.M., 1968, c. 31, s. 5.

Removal of pituitary gland.

6 (1) Notwithstanding that no direction has been given under this or any other Act of the Legislature with respect to the use of the body after death or the removal of parts from the body after death, any person performing a post mortem examination of a body may, without incurring any liability therefor, remove the pituitary gland from the body and cause it to be delivered to any person or agency designated by the Inspector of Anatomy appointed under The Anatomy Act for use in the treatment of persons having a growth hormone deficiency.

En. S.M. 1979, c. 20, s. 1.

Where section does not apply.

6 (2) This section does not apply where the person performing the post mortem examination of the body has reason to believe

(a) that the deceased would, if living, have objected to the removal of the pituitary gland for use in the treatment of persons having a growth hormone deficiency; or

b that

(i) the surviving spouse of the deceased, or

(ii) if none, any of his children 18 years of age or over, or

(iii) if none, either of his parents, or

(iv) if none, any of his brothers or sisters 18 years of age or over,

objects to the removal of the pituitary gland for use in the treatment of persons having a growth hormone deficiency.

En. S.M. 1979, c. 20, s. 1.

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APPENDIX B

Uniform Human Tissue Gift Act

(Revised 1971)

Interpretation

1. In this Act,

(a) "consent" means a consent given under this Act;

(b) "physician" means a person (to be adapted to refer to licensing or registration under provincial Medical Act);

(c) "tissue" includes an organ, but does not include any skin, bone, blood, blood constituent or other tissue that is replaceable by natural processes of repair;

(d) "transplant" as a noun means the removal of tissue from a human body, whether living or dead, and its implantation in a living human body, and in its other forms it has corresponding meanings;

(e) "writing" for the purposes of Part II includes a will and any other testamentary instrument whether or not probate has been applied for or granted and whether or not the will or other testamentary instrument is valid.

PART I—*INTER VIVOS* GIFTS FOR TRANSPLANTS

Transplants under Act are lawful

2. A transplant from one living human body to another living human body may be done in accordance with this Act, but not otherwise.

Consent for transplant

3. (1) Any person who has attained the age of majority, is mentally competent to consent, and is able to make a free and informed decision may in a writing signed by him consent to the removal forthwith from his body of the tissue specified in the consent and its implantation in the body of another living person.

Consent for person under age, etc.

(2) Notwithstanding subsection 1, a consent given thereunder by a person who had not attained the age of majority, was not mentally competent to consent, or was not able to make a free and informed decision is valid for the purposes of this Act if the person who acted upon it had no reason to believe that the person who gave it had not attained the age of majority, was not mentally

competent to consent, and was not able to make a free and informed decision, as the case may be.

Consent is full authority to proceed

(3) A consent given under this section is full authority for any physician,

(a) to make any examination necessary to assure medical acceptability of the tissue specified therein; and

(b) to remove forthwith such tissue from the body of the person who gave the consent.

Stale consent void

(4) If for any reason the tissue specified in the consent is not removed in the circumstances to which the consent relates, the consent is void.

PART II—*POST MORTEM* GIFTS FOR TRANSPLANTS AND OTHER USES

Consent by person for use of his body after death

4. (1) Any person who has attained the age of majority may consent,

(a) in a writing signed by him at any time; or

(b) orally in the presence of at least two witnesses during his last illness,

that his body or the part or parts thereof specified in the consent be used after his death for therapeutic purposes, medical education or scientific research.

Where donor under age

(2) Notwithstanding subsection 1, a consent given by a person who had not attained the age of majority is valid for the purposes of this Act if the person who acted upon it had no reason to believe that the person who gave it had not attained the age of majority.

Consent is full authority, exception

(3) Upon the death of a person who has given a consent under this section, the consent is binding and is full authority for the use of the body or the removal and use of the specified part or parts for the purpose specified, except that no person shall act upon a consent given under this section if he has reason to believe that it was subsequently withdrawn.

Consent by spouse, etc., for use of body after death

5. (1) Where a person of any age who has not given a consent under section 4 dies, or in the opinion of a physician is incapable of giving a consent by reason of injury or disease and his death is imminent,

(a) his spouse of any age; or

(b) if none or if his spouse is not readily available, any one of his children who has attained the age of majority; or

(c) if none or if none is readily available, either of his parents; or

(d) if none or if neither is readily available, any one of his brothers or sisters who has attained the age of majority; or

(e) if none or if none is readily available, any other of his next of kin who has attained the age of majority; or

(f) if none or if none is readily available, the person lawfully in possession of the body other than, where he died in hospital, the administrative head of the hospital,

may consent,

(g) in a writing signed by the spouse, relative or other person; or

(h) orally by the spouse, relative or other person in the presence of at least two witnesses; or

(i) by the telegraphic, recorded telephonic, or other recorded message of the spouse, relative or other person,

to the body or the part or parts thereof specified in the consent being used after death for therapeutic purposes, medical education or scientific research.

Prohibition

(2) No person shall give a consent under this section if he has reason to believe that the person who died or whose death is imminent would have objected thereto.

Consent is full authority, exceptions

(3) Upon the death of a person in respect of whom a consent was given under this section the consent is binding and is, subject to section 6, full authority for the use of the body or for the removal and use of the specified part or parts for the purpose specified except that no person shall act on a consent given under this section if he has actual knowledge of an objection thereto by the person in respect of whom the consent was given or by a person of the same or closer relationship to the person in respect of whom the consent was given than the person who gave the consent.

Person lawfully in possession of body, exceptions

(4) In subsection 1, "person lawfully in possession of the body" does not include,

(a) the supervising coroner or a coroner in possession of the body for the purposes of *The Coroners Act* (to be adapted to provincial requirements);

(b) the Public Trustee in possession of the body for the purpose of its burial under *The Crown Administration of Estates Act* (to be adapted to refer to provincial provisions for administration of estates by the Crown);

(c) an embalmer or funeral director in possession of the body for the purpose of its burial, cremation or other disposition; or

(d) the superintendent of a crematorium in possession of the body for the purpose of its cremation.

Coroner's direction

6. Where in the opinion of a physician, the death of a person is imminent by reason of injury or disease and the physician has reason to believe that section of *The Coroners Act* (to be adapted to refer to provincial provisions making the death a coroner's case) may apply when death does occur and a consent under this Part has been obtained for a post-mortem transplant of tissue from the body, a coroner having jurisdiction, notwithstanding that death has not yet occurred, may give such directions as he thinks proper respecting the removal of such tissue after the death of the person, and every such direction has the same force and effect as if it had been made after death under section of *The Coroners Act* (to be adapted to refer to provincial provision empowering coroner to permit interference with body after death).

Determination of death

7. (1) For the purposes of a post-mortem transplant, the fact of death shall be determined by at least two physicians in accordance with accepted medical practice.

Prohibition

(2) No physician who has had any association with the proposed recipient that might influence his judgment shall take any part in the determination of the fact of death of the donor.

Idem

(3) No physician who took any part in the determination of the fact of death of the donor shall participate in any way in the transplant procedures.

Exception

(4) Nothing in this section in any way affects a physician in the removal of eyes for cornea transplants.

Where specified use fails

8. Where a gift under this Part cannot for any reason be used for any of the purposes specified in the consent, the subject matter

of the gift and the body to which it belongs shall be dealt with and disposed of as if no consent had been given.

PART III—GENERAL

Civil liability

9. No action or other proceeding for damages lies against any person for any act done in good faith and without negligence in the exercise or intended exercise of any authority conferred by this Act.

Sale, etc., of tissue prohibited

10. No person shall buy, sell or otherwise deal in, directly or indirectly, for a valuable consideration, any tissue for a transplant, or any body or part or parts thereof other than blood or a blood constituent, for therapeutic purposes, medical education or scientific research, and any such dealing is invalid as being contrary to public policy.

Disclosure of information

11. (1) Except where legally required, no person shall disclose or give to any other person any information or document whereby the identity of any person,

(a) who has given or refused to give a consent;

(b) with respect to whom a consent has been given; or

(c) into whose body tissue has been, is being or may be transplanted,

may become known publicly.

Exception

(2) Where the information or document disclosed or given pertains only to the person who disclosed or gave the information or document, subsection 1 does not apply.

Lawful dealings not affected, exception

12. Any dealing with a body or part or parts thereof that was lawful before this Act came into force shall, except as provided in this Act, continue to be lawful.

Offence

13. Every person who knowingly contravenes any provision of this Act is guilty of an offence and on summary conviction is liable to a fine of not more than $1,000 or to imprisonment for a term of not more than six months, or to both.

Application of *The Coroners Act*

14. Except as provided in section 6, nothing in this Act affects the operation of *The Coroners Act* (to be adapted to provincial requirements).